

042004

ROTRUCK FUNERAL HOME
85 S. MAIN STREET
KEYSER, WVA 26726STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
			LEONA	ARDELLA	ALLEN	JANUARY 28, 1986			1:16 R				
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE	IN YEARS (LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 21 HRS HOURS MIN.		
Female			White	MONTH	DAY	YEAR	74						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			SACRED HEART HOSPITAL			Retired			Candy Corp.				
13a. STATE WV			13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12 North Main Street 26726							
FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Homer					Boettner	Lula							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No -- 235-16-0885			17. INFORMANT	1080 Georgia Avenue Delores Seibel Keyser, WV 26726						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))			respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia & Empysema										
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/19/86 to 1/28/86. I certify that (I) (we) last saw the deceased alive on 1/28/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE RICHARD SCHMITT, M.D.			DEGREE			22c. DATE SIGNED 1/29/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 900 SETON DRIVE, CUMBERLAND, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/31/86	23c. NAME OF CEMETERY OR CREMATORIAL Potomac Memorial Gardens			23d. LOCATION CITY OR TOWN Keyser, Mineral	COUNTY	STATE	WV			
24. FUNERAL DIRECTOR NAME A. Craig Rotruck 85 S Main St Keyser, WV 26726			25a. DATE RECEIVED BY REGISTRAR FEB 05 1986			25b. SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in the funeral director's office. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial. (Checkmark "B" on page 1 indicates that this certificate is filed with the State Dept. of Health and Mental Hygiene.)

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

101 W. 42ND STREET
NEW YORK, N.Y.
TELEGRAMS

9 AM 10 APR 1945 YOUNG, JAMES M., JR., ALICE, MARY

101 W. 42ND STREET
NEW YORK, N.Y.

YOUNG, JAMES M., JR., ALICE, MARY

APPROVED FOR RELEASE

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10 APR 2010 BY SP2 CDR CHUCK HARRIS

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00002

REG. NO.

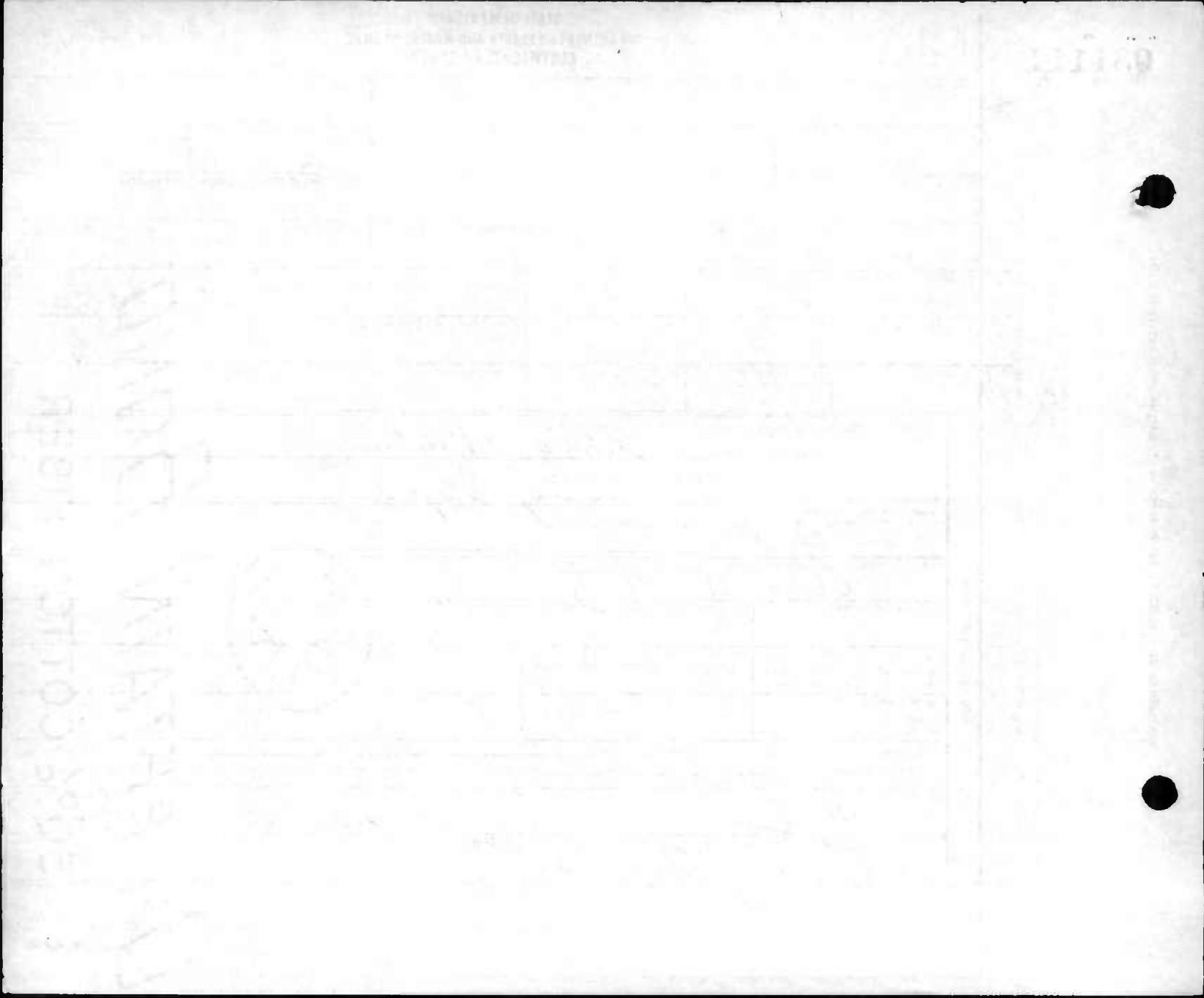
1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Elroy Hilry Barnes							January 24, 1986				M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Male		White		March 21, 1909			76						
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.A.					Allegany County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			17b. KIND OF BUSINESS OR INDUSTRY						
Cumberland		Sacred Heart Hospital					Coal						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Allegany		Cumberland				1001 Harding Ave. 21502					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Gust		Hilry	Barnes	Maude					Mulledy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
No		214-07-4977		David M. Barnes			same as 13a-e.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive pulmonary Disease, atrial fibrillation</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Rajithan</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>1/24/86</i>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>N.A. Rajithan MD.</i>		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE		
Burial		1/27/86	Branch Mountain		Springfield		Hampshire		W. VA.				
24. FUNERAL DIRECTOR NAME		Leasure-Stein Funeral Home		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
						JAN 29 1986							
230 baltimore Ave. Cumberland, MD 21502													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper page 2 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. If item 18 shows any injury, or other traumatic event, the medical examiner must be notified and cause of death must be certified by the medical examiner.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and cause of death must be certified by the medical examiner.



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

Scarpelli Funeral Home STATE OF MARYLAND
108 Virginia Avenue DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Cumberland, Md. 21502 CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harold J Barnes			2a. DATE OF DEATH MONTH DAY YEAR 01 10 86	2b. HOUR 03:55PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 01-13-1906	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH ACTIVITY, GIVE STREET ADDRESS) Sacred Heart Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) construction foreman
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1500C Old Towne Manor Apts./21502
14. FATHER'S NAME FIRST Howard	MIDDLE C. Barnes	LAST	15. MOTHER'S MAIDEN NAME FIRST Cora B. Davisson	MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	16c. ADDRESS 190108514	17. INFORMANT Mrs. Beulah Barnes, Cumberland, MD - wife	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Aner</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute autoseptal MI</i>				
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe CHD coronary MI (superior)</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Dabetes II</i> - <i>large cell carcinoma of lung & lymphatic spread</i>				
19a. DATE OF OPERATION <i>1/12/86</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Octocle Cancer Prostate</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>fall</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET <i>925 Bishop Walsh Road</i>	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>1/13/86</i> , 19 <i>86</i> , to <i>1/10/86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>19 86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Dr. V. Rual Felipa</i>				
DEGREE <i>MD</i>				
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED <i>1/12/86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. V. Rual Felipa				
22e. ADDRESS 925 Bishop Walsh Road, Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01-13-1986	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION CITY OR TOWN Cumberland	COUNTY STATE Allegany MD
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502	ADDRESS	25. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE JAN 16 1986		

• L. L. •

014035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from page 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be paged at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Silcox Merritt Funeral Service
1 - STATE REGISTRAR 404 Decatur Street
Cumberland, Md. 21502 CERTIFICATE OF DEATH

00004

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE Joseph	LAST Beck	20. DATE OF DEATH MONTH January	DAY 02	YEAR 1986	20. HOUR 01:55am		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH OCT			YEAR 23 1932	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 53	YRS. DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) KELLY SPRINGFIELD TIRE CO.			12b. KIND OF BUSINESS OR INDUSTRY 21502		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST JOHN			MIDDLE M.			LAST BECK			15. MOTHER'S MAIDEN NAME FIRST BESSIE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. KOREAN WAR			16c. ADDRESS 217-30-2140			17. INFORMANT ADDRESS DOROTHY BECK RED 3 BEDFORD ROAD CUMBERLAND MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pseudomonas sp. Bronchopulmonary infection.</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Squamous Cell Carcinoma of Liver. Right Preurectomy. Severe Bronchospasm</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dr. Kenneth Zienkiewicz</i>			22c. DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>JAN 2, 1986</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kenneth Zienkiewicz			22f. ADDRESS 925 Bishop Walsh Road, Cumberland, Md. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN 4 1986			23c. NAME OF CEMETERY OR CREMATORIUM ROCKY GAP VET CEMETERY			23d. LOCATION FLINTSTONE RFD ALLEGANY MARYLAN		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.						25a. DATE REC'D. BY REGISTRAR JAN 7 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>		

10. *Leucania* *luteola* (Hufnagel) *luteola* Hufnagel, 1808.

Technique 2003

98-0-175

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SILCOX/MERRITT FUNERAL HOME STATE OF MARYLAND
404 DECATOR STREET DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CUMBERLAND, MD 21502 CERTIFICATE OF DEATH

8600005

1. FOR STATE REGISTRAR			404 DECATOR STREET CUMBERLAND, MD 21502			DEPARTMENT OF HEALTH AND MENTAL HYGIENE		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		
MABEL EDNA BECK						JANUARY 14 1986		
3. SEX			4. RACE			5. DATE OF BIRTH		
FEMALE			WHITE			MONTH DAY YEAR JULY 22 1907		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SAME FACILITY, GIVE STREET ADDRESS SACRED HEART HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 808 EDGEWOOD DRIVE 21502					
14. FATHER'S NAME WILSON			MIDDLE W. WARNER LAST			15. MOTHER'S MAIDEN NAME CLARA GRIFFITH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-38-0230			17. INFORMANT BEVERLY BAUER RFD 3 BOX 134K CUMBERLAND MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cystadenocarcinoma ovary</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mon		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			(b)					
(c)			DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19 86</i> to <i>Jan 14 1986</i> , that (I) (we) last saw the deceased alive on <i>Jan 14 1986</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>W. E. Springer</i>			22c. DEGREE			22d. DATE SIGNED <i>Jan 14 86</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. E. Springer</i>			22f. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN 16 1986			23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK		
23d. LOCATION CITY OR TOWN CUMBERLAND ALLEGANY MARYLAND			23e. DATE REC'D. BY REGISTRAR JAN 17 1986			23f. REGISTRAR'S SIGNATURE <i>Jeanne Springer</i>		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND ADDRESS								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an attorney-at-law or medical examiner must be notified once

TELEGRAMS 1012

CHAPTER 10 INDEX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner will be notified.

BOALS FUNERAL HOME

111 CHURCH ST.
WESTERNPORT, MD. 21562STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

031103

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
BILLIE			NMI	BRASHEAR		JANUARY 22, 1986				7:10P
3. SEX		MALE	4. RACE	WHITE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
					AUGUST	14	1930	55	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MARYLAND	7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY			
10. CITY OR TOWN OF DEATH		CUMBERLAND	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (CHAUFFEUR POSTMAN HOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING			
13a. STATE MARYLAND		13b. COUNTY ALLEGANY	14. CITY OR TOWN WESTERNPORT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 215 MILLER ST. 21562			
14. FATHER'S NAME		WILLIAM	MIDDLE	BRASHEAR	15. MOTHER'S MAIDEN NAME		MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO 215266232		17. INFORMANT		ADDRESS LOLA BRASHEAR WESTERNPORT, MD. 21562			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))		Metastatic Adenocarcinoma primary site unknown								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b)								
		DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED NOT WHILE AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		22c. DATE SIGNED 1-24-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 925 BISHOP WALSH RD. CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/25/86		23c. NAME OF CEMETERY OR CREMATORIUM MILLER CEMETERY		23d. LOCATION WESTERNPORT ALLEGANY MD				
24. FUNERAL HOME BOALS FUNERAL SERVICE, P.A. WESTERNPORT, MD.				25a. DATE REC'D. BY REGISTRAR JAN 29 1986		25b. REGISTRAR'S SIGNATURE John Pendleton				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR		
			AUGUST	TRAGO	BRUST, JR.	JANUARY 30, 1986				1:54A _M		
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS						IF UNDER 24 HRS HOURS MIN.	
Male	White	October 9, 1918			67 YRS							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD					
Maryland	U.S.A.											
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor/P.R. Dir.						12b KIND OF BUSINESS OR INDUSTRY Newspaper Westvaco		
CUMBERLAND	MEMORIAL HOSPITAL											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 120 Greene Street / 21502						
Maryland	Allegany	Cumberland										
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
	August	Trago	Brust, Sr.	Olive								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)				16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Yes				W.W.II			Anna Brust-Address same as #13 above.					
18 CAUSE OF DEATH (Enter only one cause per line for Part I and II) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophagus</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>II</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a I certify that (I) this hospital attended the deceased from 1-29, 1984, to 1-30, 1984, that (we) last saw the deceased alive on 1-27, 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death.												
22b SIGNATURE <u>DR. T. Williams</u>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 30 Jan 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						MEMORIAL HOSPITAL MEDICAL BUILDING						
DR. T. WILLIAMS						CUMBERLAND, MARYLAND 21502						
23a BURIAL, CREMATION, REMOVAL SPECIFY			23b. DATE 2-2-86			23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park			23d. LOCATION CITY OR TOWN			
Burial									COUNTY STATE			
24 FUNERAL DIRECTOR NAME			George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Maryland 21502			25a DATE REC'D. BY REGISTRAR FEB 03 1986			25b. REGISTRAR'S SIGNATURE <u>Gloria Davidson-Pendell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours of death. Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial; cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ROBERT S. BUCCI						January 8, 1986				8:12 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Male	White	MONTH	DAY	YEAR	51	YRS	MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
PA		USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			Memorial Hospital			salesman			auto parts				
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
13a. STATE PA	13b. COUNTY Somerset	13c. CITY OR TOWN Meyersdale				RD#1 15552			99999				
14. FATHER'S NAME			FIRST Nick	MIDDLE	LAST Bucci	15. MOTHER'S MAIDEN NAME			LAST Emanuele				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
No			185-26-8178			Nick Bucci 311 21st St. Windber, PA 15963							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cards/Respiratory Arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Hemorrhage</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>NIA</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Hypertension</u>													
MEDICAL CERTIFICATION		19a. DATE OF OPERATION <u>N/A</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>			20a. AUTOPHY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>N/A</u> 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1b, PART I, OR PART II <u>N/A</u>		21d. LOCATION STREET <u>N/A</u> CITY OR TOWN <u>Holiday</u> COUNTY <u>PA</u> STATE <u>PA</u>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WORKING AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>											
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24/85</u> , 19 <u>85</u> , to <u>1/8/86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>12/24/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. DATE SIGNED <u>1/8/86</u>							
22b. SIGNATURE <u>Howard Diener</u>						DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>1/8/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Figueroa / Dr. Howard Diener						22e. ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Jan. 11, 1986		23c. NAME OF CEMETERY OR CREMATORIUM St. Anthony's Cem.			23d. LOCATION CITY OR TOWN Windber		COUNTY Somerset		STATE PA		
24. FUNERAL DIRECTOR NAME <u>Jeanne R. Dulle Valle</u>		ADDRESS Windber, PA 15963			25a. DATE REC'D. BY REGISTRAR JAN 12 1986			25b. REGISTRAR'S SIGNATURE <u>Jeanne R. Dulle Valle</u>					

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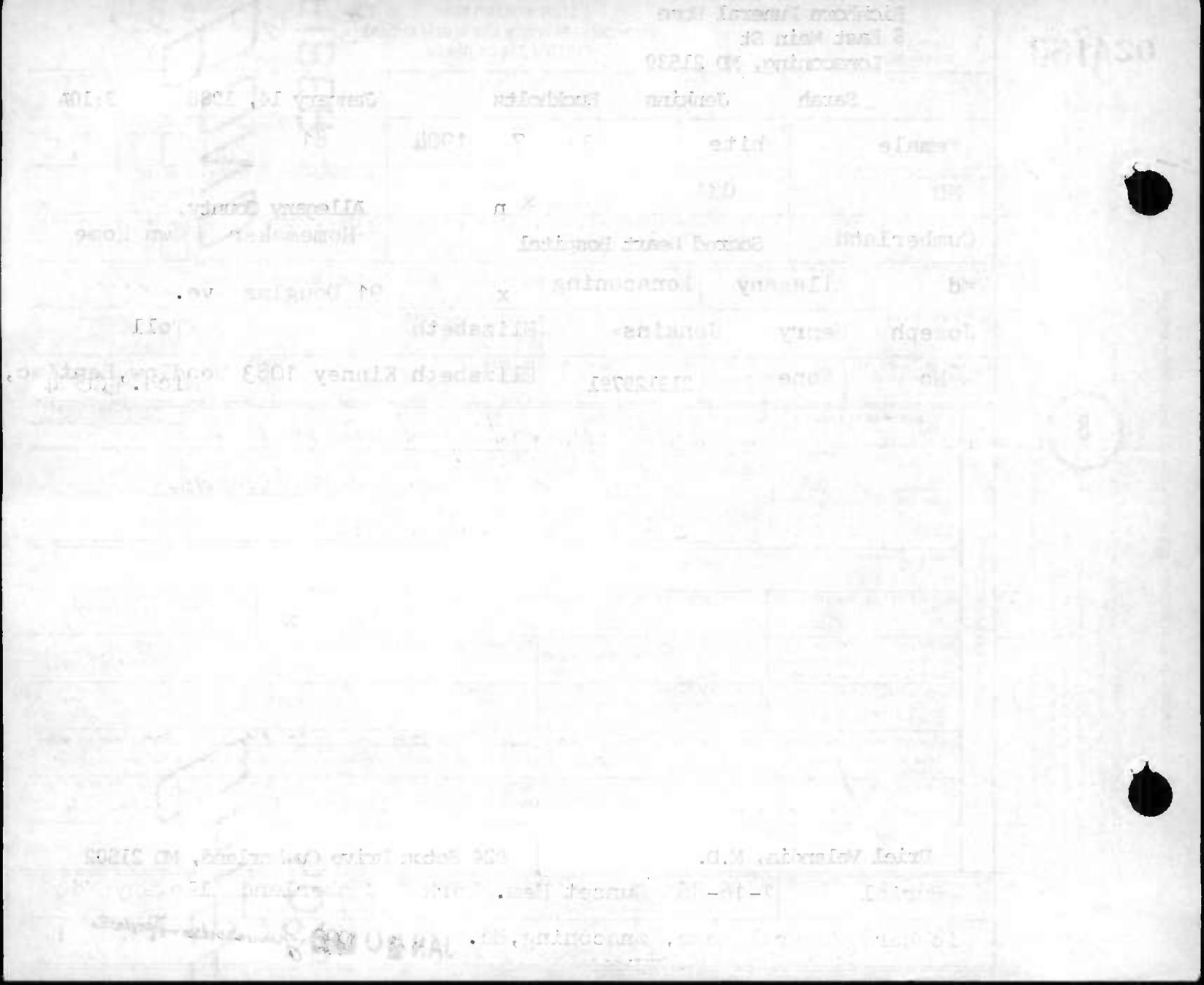
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove this certificate from paper. If either the medical examiner or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Eichhorn Funeral Home 8 East Main St Lonaconing, MD 21539			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						
					REG. NO. 00009				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Sarah	MIDDLE Jenkins	LAST Buckholtz	2a. DATE OF DEATH January 14, 1986	MONTH YEAR	2b. HOUR 3:10A M	
3. SEX Female			4. RACE White	5. DATE OF BIRTH 3 MONTH 7 DAY 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN) MD			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County			
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital			12a. USUAL OCCUPATION (TYPE OR PRINT) Homemaker			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md Allegany Lonaconing			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 91 Douglas Ave. 20650			
14. FATHER'S NAME Joseph Henry Jenkins			15. MOTHER'S MAIDEN NAME Elizabeth			16. KIND OF BUSINESS OR (TYPE OR PRINT) Own Home			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No			16b. SOCIAL SECURITY NO. 213129791			16c. INFORMANT Elizabeth Kinney ADDRESS 1083 Woodlow, Pontiac, Mich. 48054			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Central alveolar hypoventilation syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHF & effusione</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>12-23</u> , 19 <u>85</u> , to <u>1-14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <u>1-14-86</u>
22b. SIGNATURE <u>Uriel Velandia</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Uriel Velandia, M.D.		22e. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-16-86		23c. NAME OF CEMETERY OR CREMATORIUM Sunset Mem. Park			23d. LOCATION Cumberland Allegany Md		
24. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md.				25a. DATE REC'D. BY REGISTRAR JAN 20 1986			25b. REGISTRAR'S SIGNATURE <u>Judith A. Donahue</u>		
BP									
DHMH - 16 50M 4/83 (VRA 15, 4)									



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00010

REG. NO.

1- STATE
REGISTRARI. DECEASED NAME
(TYPE OR PRINT)

FIRST Loretta MIDDLE Mae LAST Burgess

2a DATE KNOWN
OF
DEATH
ESTI-
MATED
 MONTH DAY YEAR
1-25-1986 20:47M

3. SEX F

4. RACE W

5. DATE OF BIRTH
MONTH DAY YEAR
5 21 216. AGE (IN YEARS
LAST BIRTHDAY)
64 YRS7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN2c. DATE
PRONOUNCED
DEAD
MONTH DAY YEAR
1-25-1986 20:47M7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) MD.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED
 NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH Allegany

10. CITY OR TOWN OF DEATH Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Memorial Hospital12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Housewife12b. KIND OF BUSINESS
OR INDUSTRY
Home

13a. STATE MD. 13b. COUNTY Allegany 13c. CITY OR TOWN Flintstone

13d. INSIDE CITY LIMITS?
YES NO 13e. STREET ADDRESS
Flintstone, MD. 21530

14. FATHER'S NAME

FIRST Lester

MIDDLE A.

LAST Boggs

15. MOTHER'S MAIDEN NAME

FIRST Rettie

MIDDLE E.

LAST Mallow

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No16b. SOCIAL SECURITY NO.
214-34-1568

17. INFORMANT

ADDRESS

Blaine Burgess Flintstone, MD. 21530

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

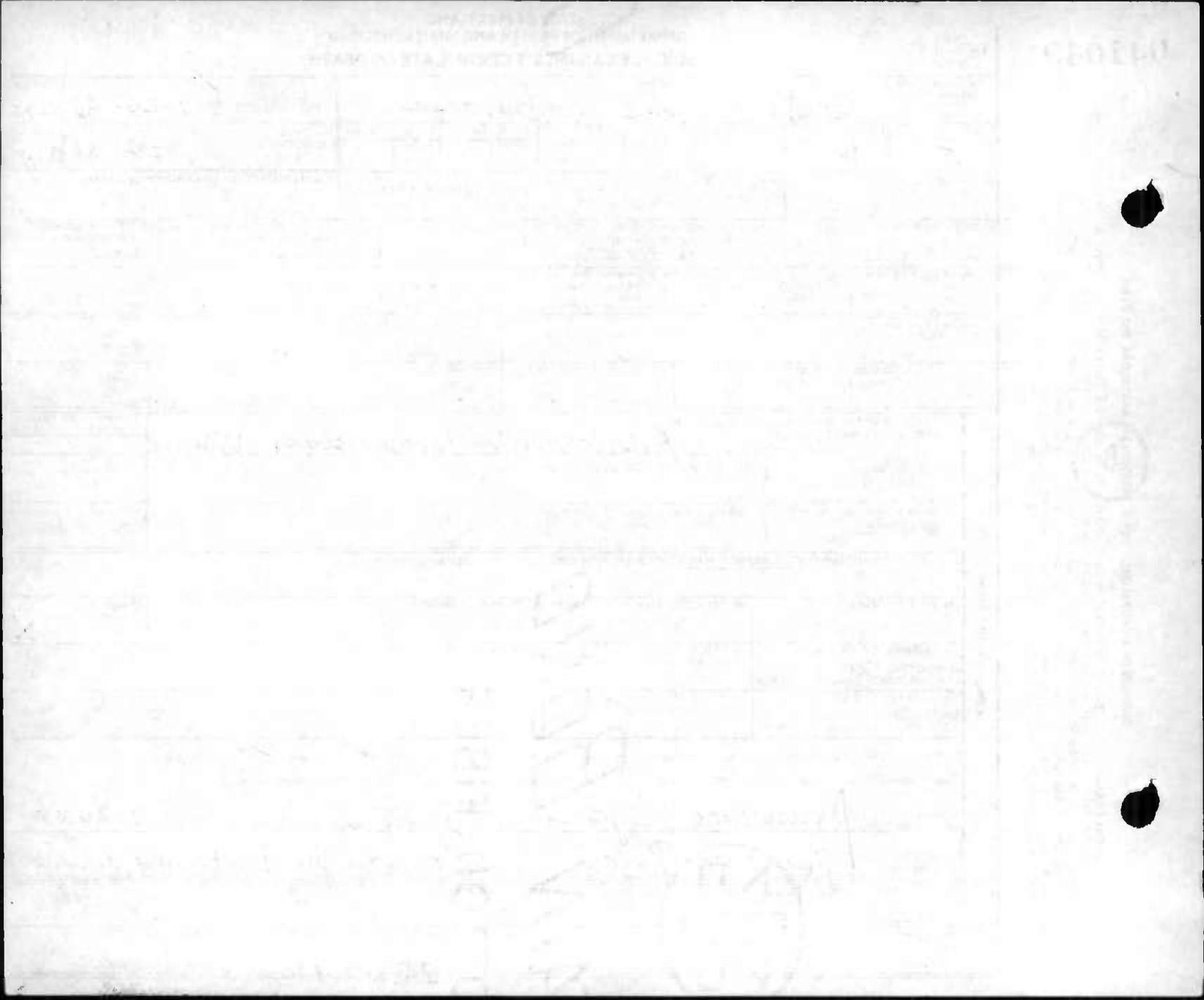
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?
YES NO 21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, EARM, ETC.) 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner .

ACTUAL SIGNATURE Francisco Reyes M.D. Deputy MEDICAL EXAMINER DATE SIGNED 1-25-86

EXAMINER'S NAME (TYPE OR PRINT) Francisco Reyes ADDRESS 900 Seton Dr. Cumberland Md. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE 23b. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION
CITY OR TOWN COUNTY STATE
Burial 1-28-86 Boggs Cemetery Seneca Rocks, Pendleton W.VA.24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Silcox-Merritt 404 Decatur St Cumb Md. 21502 500-03-1986 John David Randall



017054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

SILCOX-MERRITT FUNERAL HOME STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR 404 DECATUR STREET CUMBERLAND, MD 21502

REG. NO. 66 00011

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
CHARLES FREDERICK BURKETT						JANUARY 5, 1986			7:30 AM		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		MARCH 10 1912		73		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
PENNA.		USA				ALLEGANY COUNTY					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL				RETIRED PAINTER AND DECORATOR					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		21602	
MARYLAND		ALLEGANY		CUMBERLAND				RFD#3 HAZEN ROAD			
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE	PRICE			
		JOHN	L.	BURKETT	ELIZABETH						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		206-01-1579		HELEN BURKETT PO BOX 807 CUMBERLAND MD.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>Carcinoma of the Lung</i>						1 yr					
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic Obstructive Lung Disease</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/24 1985 to 1-5-1986, that (I) (we) last saw the deceased alive on 1-5-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John S. Burkett</i>						DEGREE					
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22d. DATE SIGNED JAN. 7-86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Spangler</i>						22f. ADDRESS 912 SETON DRIVE, BMG CUMBERLAND, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 8 1986		23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK		23d. LOCATION CUMBERLAND ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND						25a. DATE REC'D. BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Pender</i>			

10-10-10
A 8815

3801 8 HAL

CHROMIC BURST FOR STERILIZATION

CHROMIC-MINIETT INDUSTRIAL INC.
16110 S. 107TH AVENUE
PO BOX 100000
CHICAGO, IL 60648

10-10-10
A 8815

CHROMIC BURST FOR STERILIZATION

10-10-10
A 8815

CHROMIC BURST FOR STERILIZATION
10-10-10
A 8815

10-10-10
A 8815 8 HAL

041012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transit parlor. Then please remove carbon paper. Pages 1 and 2 should be left with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23 is marked as item 18, then any injury, or other traumatic event, the medical certifier must sign below.

SILCOX MERRITT FUNERAL
404 DECATUR ST
CUMBERLAND, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00012

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
WINFIELD I BURTON						JANUARY	29,	1986		9:30 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
MALE			WHITE			MONTH DAY YEAR			IF UNDER 1 YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
W.VA.			USA						ALLEGANY COUNTY		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY ALLEGANY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 103 FOREST DRIVE SUNSET VIEW		
14. FATHER'S NAME ERVIN			15. MOTHER'S MAIDEN NAME LOUISA								
FIRST MIDDLE LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI			17. INFORMANT			ADDRESS		
YES			214 05 7870			HAZEL BURTON			103 FOREST DRIVE CUMBERLAND MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest.</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CAD</i> DOUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Ca rectate. Cecrebraland drcere</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Haimov</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/31/86		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER HAIMOV			22f. ADDRESS 1 MEMORIAL DR. CUMBERLAND, MD 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB 1 1986			23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK			23d. LOCATION CUMBERLAND ALLEGANY MD.		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL HOME			ADDRESS CUMBERLAND, MARYLAND			25a. DATE REC'D. BY REGISTRAR FEB 04 1986			25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendleton</i>		

041050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00013

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			GERTRUDE BUSH			JANUARY 27, 1986			6:17A M		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR		
FEMALE		CAUCASIAN	08/30/1926			59			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY			MD.		
PA		PANAMA USA	10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		
13a. STATE PA		13b. COUNTY BEDFORD	13c. CITY OR TOWN HYNDMAN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS (ZIP CODE) CHARLES STREET / 15545		
FATHER'S NAME FIRST: WILLIAM		MIDDLE: BENJAMIN LAST: ELFRIEDA	15. MOTHER'S MAIDEN NAME						MIDDLE: LONG		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 166-32-2738			17. INFORMANT			ADDRESS CHARLES E. BUSH, JR., BOX 291, HYNDMAN, PA 15545			
18. CAUSE OF DEATH (Enter only one cause per line for item 18) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) SPINAL MUSCULAR ATROPHY YEARS (c) ACUTE BRONCHITIS, PNEUMONIA YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SUPRA VENTRICULAR TACHYCARDIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1/26/86 to 1/27/86 , that (I) (we) last saw the deceased alive on 1/26/86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John M. Moore FOR Dr. Gore</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/28/86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GORE		22f. ADDRESS Memorial Hospital, Cumberland, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/86		23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery			23d. LOCATION Hyndman, Bedford, PA				
24. FUNERAL DIRECTOR NAME Harvey H. Zeigler		ADDRESS Hyndman, PA 15545			25a. DATE REC'D. BY REGISTRAR 1/28/86			25b. REGISTRAR'S SIGNATURE <i>John M. Moore</i>			

DO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached by you as the burial permit. Then please remove control seal. Item 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

RECORDED IN THE

REGISTRY

OF THE

STATE

OF CALIFORNIA

BY THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

028006

FOR STATE REGISTRAR			BOALS FUNERAL HOME 111 CHURCH STREET WESTERNPORT, MD 21552			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. 00014				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST						2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
ELIZABETH LORETTA CARTER									JANUARY 21, 1986				1:11 P.M.
2. SEX Female			3. RACE White			4. DATE OF BIRTH MONTH 3 DAY 15 YEAR 1898			5. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lonaconing Silk			12b. KIND OF BUSINESS OR INDUSTRY Silk				
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Midland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Railroad St. 21542		
14. FATHER'S NAME FIRST Thomas MIDDLE P. LAST Coorigan						15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Foutz LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-1766			17. INFORMANT Mrs. Rose Nolam			ADDRESS Midland, Md. 21542				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						CARDIO RESPIRATORY FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			{			DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY METASTASIS							
			{			DUE TO, OR AS A CONSEQUENCE OF (c) ENDOMETRIAL CARCINOMA OF UTERUS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Dec. 17, 1985 to JAN. 21, 1986 , that (I) (we) last saw the deceased alive on JAN. 20, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE S Chang			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/21/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SATURNINA CHANG, MD			22e. ADDRESS FROSTBURG PLAZA, FROSTBURG, MD 21532										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/21/86			23c. NAME OF CEMETERY OR CREMATORIUM St. Joseph Cemetery			23d. LOCATION CITY OR TOWN Midland COUNTY Allegany STATE Md.				
24. FUNERAL DIRECTOR NAME Boals Funeral Service			25a. DATE REC'D. BY REGISTRAR JAN 24 1986			25b. REGISTRAR'S SIGNATURE Boals Funeral Service							
BP _____													
DHMH - 16 60M 7/B4 (VRA 15, 4)													

GOALS FOR LEADERSHIP HOME
111 OLYMPIC STREET
ESTABLISHED IN 1939

1981 NOVEMBER

CARTER

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SACRED HEART HOSPITAL

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please affix postage stamps. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, to Bureau of Vital Statistics, 201 W. Preston Street, Baltimore, Maryland 21201.

IMPORTANT: If Item 21 is marked as "Notify Medical Examiner", the medical examiner must be notified at once.

024186

DURST FUNERAL HOME FOR STATE REGISTRAR 57 FROSS AVE. FROSTBURG, MD 21532			#15, Film #59786 Kam STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH	REG. NO. 00015
1. DECEASED NAME (TYPE OR PRINT) WALTER DUDLEY CAVERT			2a DATE OF DEATH JANUARY 10, 1986	2b HOUR 2:10 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 18, 1891	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 94 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 months 0 days 0 hours 0 min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN La Vale	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 710 La Vale Terr., 21502
14. FATHER'S NAME FIRST William	MIDDLE I.	LAST Cavert	15. MOTHER'S MAIDEN NAME FIRST Elizabeth	MIDDLE Mary
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) W.W. 1 123-28-0081	17. INFORMANT Elizabeth Adams, La Vale Md. 21502	ADDRESS 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia bilateral</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF, DSGVD, decomp</i>				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, check here.)				
22b. PHYSICIAN'S NAME (TYPE) SHIN KIM	22c. DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Jan. 11 '86	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory	23d. LOCATION CITY OR TOWN Smithsburg, Md.	STATE
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.				
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 20 1986				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00016

037176

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST John	MIDDLE Arthur	LAST Clair	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 1 31 86	MONTH YEAR	2b. HOUR 2300A	
3 SEX Male	4 RACE Cau	5. DATE OF BIRTH MONTH 7	DAY 1	YEAR 31	6 AGE (IN YEARS LAST BIRTHDAY) 54 yrs	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA - Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. DATE Pronounced DEAD <input checked="" type="checkbox"/> 2 1 86		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 200 Avirett Ave Cumberland Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painting Contractor(self emp)		
13. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> XXX		13e. STREET ADDRESS 200 Avirett Ave	12b. KIND OF BUSINESS OR INDUSTRY 21502		
14. FATHER'S NAME FIRST William Thomas Clair		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Bessy		MIDDLE A.	LAST Simpson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-26-9382		17. INFORMANT Lois Marlene Eversole Rt 2 Box 243 Ridgley West Virginia		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) <u>Acute gastro-esophageal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Barrett's esophagus with hiatal hernia</u>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>								
1 hour								
1-2 years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Ventriculomegaly(hydrocephalus): Coronary artery heart disease</u>								
19a. DATE OF OPERATION 10/3085		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Hiatal hernia/Barret's esophagus</u>				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Balto. J. Snow, M.D.</u>								
TITLE (SPECIFY) <u>Dpty</u> M.D. MEDICAL EXAMINER								
DATE SIGNED <u>2/1/86</u>								
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.		ADDRESS <u>Memorial Hospital, Cumberland Md</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/1/86		23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.		23d. LOCATION CITY OR TOWN COUNTY		
STATE								
24 FUNERAL DIRECTOR NAME Anatomy Board		25a. DATE REC'D. BY REGISTRAR FEB 05 1986						
25b. REGISTRAR'S SIGNATURE <u>J. L. Davidson, Jr.</u>								

100



TO HOSPITAL OR ATTENDING PHYSICIAN. The services of the hospital or attending physician

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00017

REF NO

I. DECEASED NAME (TYPE OR PRINT) TINA Elenora CLINE			LAST	2a. DATE OF DEATH Jan. 25, 1986	MONTH	DAY	YEAR	2b. HOUR 9:00 a.m.
1. SEX Female	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR July 7 1916	6. AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --		
13a. STATE WV		13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1410 Terri Street 26726		99999	
14. FATHER'S NAME FIRST John		MIDDLE W.	LAST Cowgill	15. MOTHER'S MAIDEN NAME FIRST Mary	MIDDLE S.	LAST Sunderlin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-82-2010		17. INFORMANT David V. Cline, Sr.		ADDRESS 1410 Terri Street Keyser, WV 26726		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNCONTROLLED SEPSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PROBABLE CHRONIC CHOLECYSTITIS/EMC								
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS 11								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. RESPIRATORY FAILURE & VIRAL PNEUMONIA								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)				
21d. THE INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (b) this hospital attended the deceased from 1/24/86 to 1/25/86 , that (b) (we) last saw the deceased alive on 1/24/86 at 19:00 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We certify (did not) view the body after death.)								
22b. SIGNATURE James M. Raver		DEGREE MN	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/09/86			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver		23b. ADDRESS 600 Memorial Ave. Cumberland, Md. 21502						
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d. DATE 1/28/86	23e. NAME OF CEMETERY OR CREMATORY Potomac Memorial Gardens		23f. LOCATION CITY OR TOWN Keyser	COUNTY Mineral	STATE WV	
24. FUNERAL DIRECTOR NAME A. Craig Rotruck		ADDRESS 85 S Main St Keyser, WV 26726	25a. DATE REC'D. BY REGISTRAR FEB 04 1986		25b. REGISTRAR'S SIGNATURE Jane Dawson Pendle			

00016

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

036049

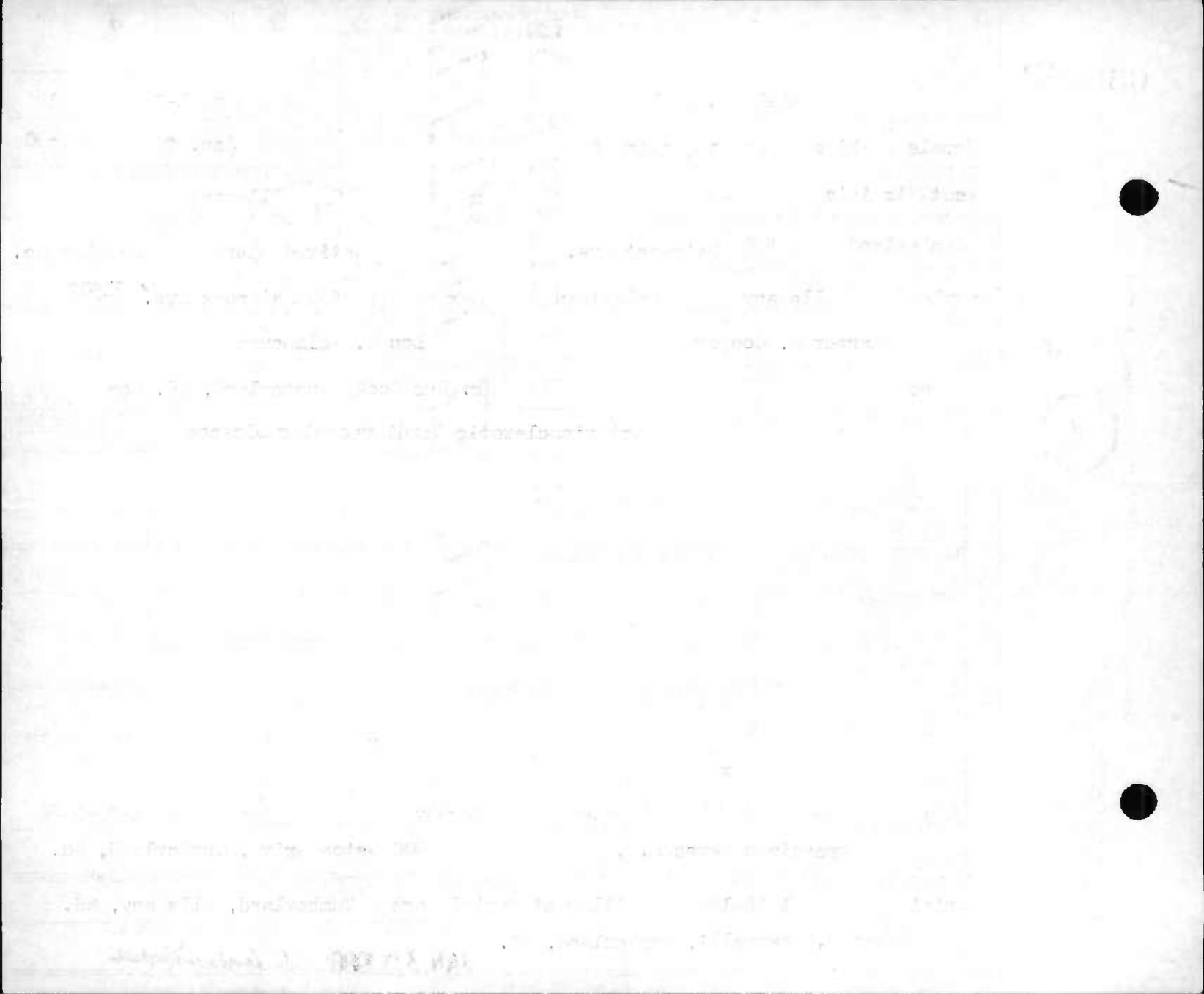
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (LAW OFFICES) WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
		Ethel E. Cook			<input checked="" type="checkbox"/>	1-26	19	86	1P		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.				2d. HOUR		
Female	White	July 16, 1917	68 yrs.						2d. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		USA			<input checked="" type="checkbox"/>	<input type="checkbox"/>	Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		550 Fairmont Ave.			Retired Clerk			Jewelry Co.			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland	Allegany	Cumberland				550 Fairmont Ave. 21502					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Harper J. Cooper				Lou W. Welshouse							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
no					Mr. Gus Cook, Cumberland, Md. Son						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Francisco Reyes			TITLE (SPECIFY) Deputy M.D.			MEDICAL EXAMINER			DATE SIGNED
EXAMINER'S NAME (TYPE OR PRINT)		Francisco Reyes, M.D.			ADDRESS			900 Seton Drive, Cumberland, Md.			1-26-1986
23a. BURIAL, CREMATION, REMOVAL PICK ONE		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Facility			23d. LOCATION CITY OR TOWN				
Burial		1-28-1986		Hillcrest Burial Park			Cumberland, Allegany, Md.			COUNTY STATE	
24. FUNERAL DIRECTOR NAME		James F. Scarpelli, Cumberland, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
					JAN 30 1986			Julia Davidson-Pandelle			



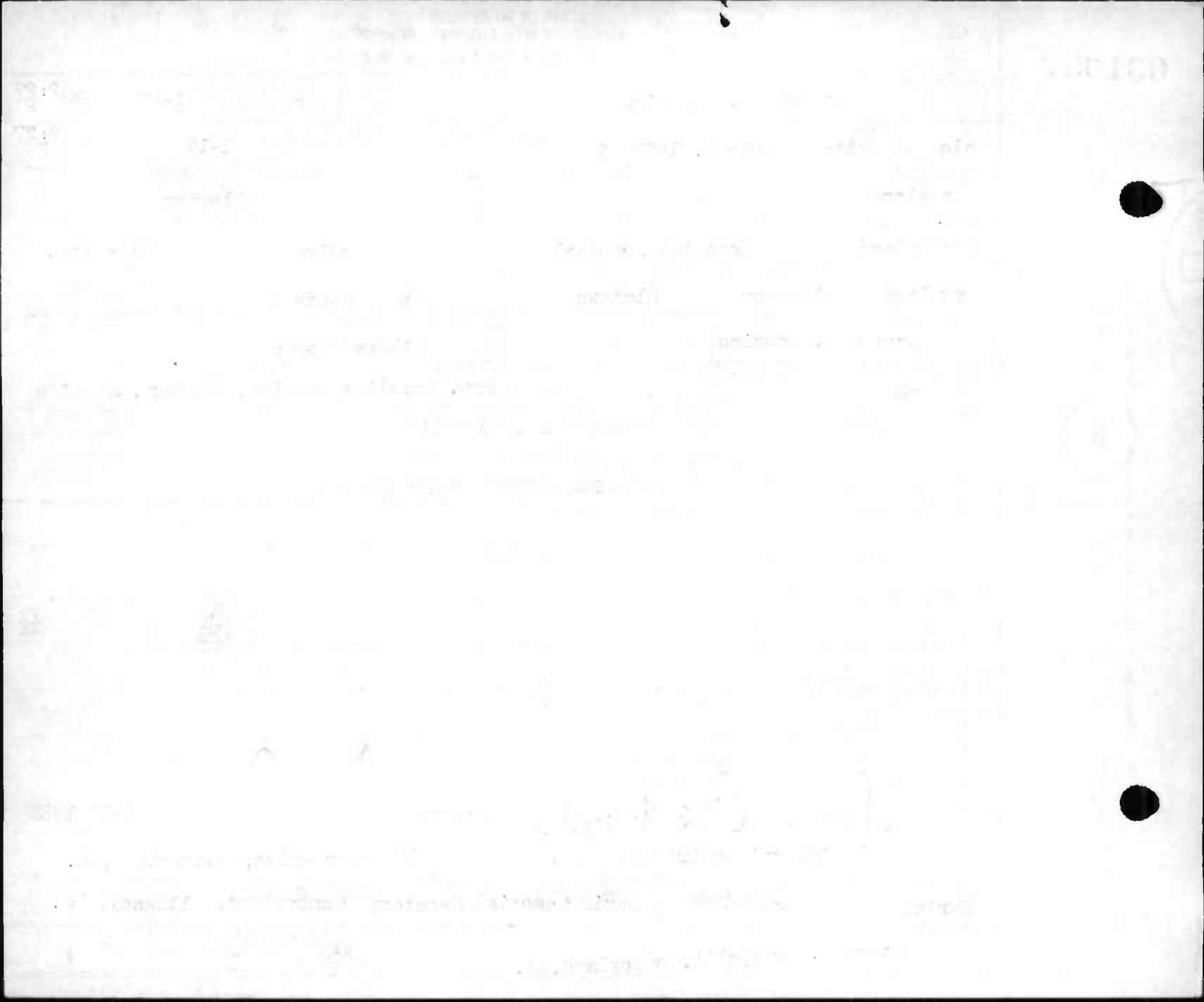
031057

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

Samuel C. Cousins						2:57 p.m.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED					
						MONTH	DAY	YEAR	1-17	1986	
1b. SEX Male			4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 2, 1929	6. AGE (IN YEARS LAST BIRTHDAY) 50 yrs	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Tire Ind.		
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Route 1				21555
14. FATHER'S NAME FIRST Samuel M. Cousins			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Mildred Woods			MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212-24-2194			17. INFORMANT ADDRESS Mrs. Madeline Cousins, Oldtown, Md Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a) through (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> } (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											DATE SIGNED 1-17-1986
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo M.D.			ADDRESS 912 Seton Drive, Cumberland, Md.								
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 1-18-1986			23c. NAME OF CEMETERY OR CREMATORIUM Davis Memorial Cemetery			23d. LOCATION CITY Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR NAME James F. Scarpelli			ADDRESS Cumberland, Md.			25a. DATE REC'D. BY REGISTRAR JAN 27 1986			25b. REGISTRAR'S SIGNATURE <i>John J. Scarpelli</i>		



037177

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8600020

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
EVELYN			M.	CRITES		January 27, 1986			5:30 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
F		W		MONTH	DAY	YEAR	71	YRS.	MONTHS	DAYS	HOURS	MIN.		
5. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
W. Va.		U.S.A.					Allegany							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland		Memorial Hospital					Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
W. Va.		Hardy		Moorefield		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 168			99999-26836		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS						
George		Benjamin	Weese		Margaret			Elizabeth			W. Va. 26836			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for item 18. If more than one cause, enter causes in Part 1a and list causes in Part 1b.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		234-42-9834		Robert S. Crites, Rt. 1, Box 168, Moorefield			Multiple Subarachnoid Hemorrhage							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Intracranial aneurysm												
		(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED AT WHILE WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Rheder Ashker, MD		22c. DEGREE		22d. DATE SIGNED 1/30/86			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Augusto Figueroa		22f. ADDRESS Memorial Hospital Medical Building Cumberland, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-30-86		23c. NAME OF CEMETERY OR CREMATORIUM Scott Cemetery			23d. LOCATION CITY OR TOWN Durgon, Moorefield, Hardy, W. V.							
24. FUNERAL DIRECTOR NAME John A. Elmore, 217 Winchester, Moorefield, W.V.		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 04 1986			25b. REGISTRAR'S SIGNATURE Julie Davison Rondell							

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that this certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as a burial-trust permit. Then please remit same to the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

999999



029038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

00021

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR	
			EMMA	C.	DANNER	01	24	86		1:45 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		White		MONTH 06 DAY 16 03 YEAR		82		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED XX WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		MD			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL & MEDICAL CENTER		12a. USUAL OCCUPATION Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Construction					
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1009 Bedford St. 21502			
14. FATHER'S NAME FIRST Charles		MIDDLE Danner		LAST		15. MOTHER'S MAIDEN NAME FIRST Louisa		MIDDLE Bachman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-05-6378		17. INFORMANT		ADDRESS George Bill Danner Spring Gap, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>Candid pulmonary heart</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i>									
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. ① GI bleeding ② Alzheimer's Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-24 1986 , to 1-24 1986 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. J. Barrera M. D.</i>		DEGREE		22c. DATE SIGNED 1-24 86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. J. Barrera M. D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial P.		23d. LOCATION CITY OR TOWN Cumberland Allegany MD					
24. FUNERAL DIRECTOR NAME William G. Kight		25a. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE <i>measures of protection</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the burial permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it

BP _____

Mr. J. D. Barnes M.D. Monrovia Ave., Competing, MD

Initial Jan. 27, 1986 Miller & Miller P.C. Competing Wilkes-Barre, PA Right Competing, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 2 and 3 should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked out, item 18 shows any injury, or other traumatic event, the medical examiner will be consulted.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 2 and 3 should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked out, item 18 shows any injury, or other traumatic event, the medical examiner will be consulted.

036048

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8600022

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST DESSIE	MIDDLE RAY	LAST DAYTON	2a. DATE OF DEATH JANUARY 29, 1986	MONTH YEAR	DAY	YEAR	2b. HOUR 2:40A.		
3. SEX Female			4. RACE White	5. DATE OF BIRTH 7 MONTH 26 DAY 1910		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? usa		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County					
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION General Services		12b. KIND OF BUSINESS OR INDUSTRY Naval Exchange				
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Westernport	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 134 Wood St. 21562					
14. FATHER'S NAME FIRST Edward			MIDDLE Dayton	LAST	15. MOTHER'S MAIDEN NAME FIRST Lucy		MIDDLE Dawson	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-09-7631 A		17. INFORMANT Mrs. Frances Greaves		ADDRESS Westernport, Md 21562					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardio-respiratory Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			DUE TO, OR AS A CONSEQUENCE OF (b) Possibly advanced small cell Ca. lung									
{ DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.												
22b. SIGNATURE <i>DR. ZAMAN</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>1/29/86</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/86		23c. NAME OF CEMETERY OR CREMATORIAL Philos Cemetery		23d. LOCATION CITY OR TOWN Westernport		COUNTY Allegany Md.		STATE		
24. FUNERAL DIRECTOR NAME <i>Wayne Boals</i>		ADDRESS Boals Funeral Service Westernport, Md. 21562		25a. DATE REC'D. BY REGISTRAR FEB 03 1986		25b. REGISTRAR'S SIGNATURE <i>John Boals</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use as the funeral director permit. Then please remove carbon paper from item 20 so that it should be filled in by the funeral director. Page 3 should be distributed for use as the funeral director permit. Then please remove carbon paper from item 20 so that it should be filled in by the funeral director. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Name 20 is marked as being "B", it shows any injury, or other traumatic event, the medical examiner should be notified.

036050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8600023

1- STATE
REGISTRAR

REG NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			MX Helen	E	Debenham	1/25/86				6:00pm	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		10/4/92		93		YEARS	MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENN SYLVANIA		United States				Allegany MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
Frostburg		Frostburg Community Hospital									
13a. STATE Maryland		13b. COUNTY Allegy		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Kaylor Circle, Frostburg, MD 21532			
14. FATHER'S NAME FIRST OSCAR		MIDDLE		LAST READING		15. MOTHER'S MAIDEN NAME FIRST ANNA		MIDDLE		WENNERMARK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO N.A.		17. INFORMANT		ADDRESS MRS. MURIEL BALLASES, MIDLOTHIAN, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ACUTE MYOCARDIAL INFARCTION											
{ DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/22/83 to JANUARY 19, 1986, that (I) (we) last saw the deceased alive on JANUARY 9, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>S. Chang</i>		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED Frostburg, MD					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chang		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1/28/86		23c. NAME OF CEMETERY OR CREMATORIUM SMITHBURG CREMATORIUM		23d. LOCATION CITY OR TOWN SMITHBURG, WASHINGTON, MD					
24. FUNERAL DIRECTOR <i>Merle M. Sowers</i> Sowers Funeral Home		60 W. MAIN ST. ADDRESS FROSTBURG		25a. DATE REC'D. BY REGISTRAR JAN 30 1986		25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Rondell</i>					

O-0000



031006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other terminal event.

IMPORTANT: If item 21 is marked or items 18 through 20 show any injury, or other traumatic event, the medical examiner must be notified.

B

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Price Funeral Home FOR STATE REGISTRAR PO BOX 119 Meyersdale, PA 15552			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. B 6 00024					
1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Michael Demarco						January 17, 1986					11:34P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 7m 1905				6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR YRS	# UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.					
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Sacred Heart Hospital				12a. USUAL OCCUPATION Distributor		12b. KIND OF BUSINESS OR INDUSTRY Produce				
13a. STATE Pa.	13b. COUNTY Somerset	13c. CITY OR TOWN Meyersdale				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 212 Broadway 99999			
14. FATHER'S NAME FIRST Jacob	MIDDLE	LAST DeMarco				15. MOTHER'S MAIDEN NAME FIRST Marietta		MIDDLE	LAST Sicoli		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 220100849	17. INFORMANT Mary DeMarco				ADDRESS 212 Broadway Meyersdale, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon & metastasis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John Mehanna</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Mehanna, M.D.		22e. ADDRESS 909-B Seton Drive, Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 20-86		23c. NAME OF CEMETERY OR CREMATORIAL Country Side Crematory		23d. LOCATION CITY OR TOWN Davidsville, Somerset, Pa.		COUNTY			STATE
24. FUNERAL DIRECTOR NAME Price Funeral Home		325 Main St. ADDRESS Meyersdale, Pa. 15552		25a. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE <i>John Anderson Pendell</i>					
DHMH - 16 50M 4/83 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troupe permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WARNING: If Item 21 is marked or hem 18 shows any injury, or other trauma, the cause of death must be noted and given in Part 18.

DURST FUNERAL HOME FROSTBURG, MD 21532

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

86 00025

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			BENJAMIN	CARL	DENNISEAR	JANUARY 13, 1986				10:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		April 5, 1907		78		YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
W. Virginia		U.S.A.				ALLEGANY COUNTY					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Cumberland		SACRED HEART HOSPITAL		Textile		Celanese					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Allegany		Mt. Savage				P.O. Box 431, 21545			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Benjamin F. Dennisear						Rebecca				Eisentroudt	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDERS)		17. INFORMANT		ADDRESS					
Yes		W.W. 2		216-09-4402		Rosetta Dennisear, Same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and 18c.) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Suite artero septal M.I.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>C.N.F.</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>C.A.D. Atrial fibrillation</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-6 1986</i> , to <i>1-13 1986</i> , that (I) (we) last saw the deceased give an <i>1-13 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edwina us.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-13-86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. U. VELANDIA MD		22e. ADDRESS 924 SETON DRIVE, CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 16 1986		23c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery		23d. LOCATION CITY OR TOWN Mt. Savage, Allegany, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 20 1986		25b. REGISTRAR'S SIGNATURE <i>Julia L. Wilson-Purcell</i>					

621130

1992 BUDGET LINE
1992 BUDGET LINE

DEALER CASH

100% 12% 10%

WILLIAMS COUNTY

100% OF THE SACRED HEART HOSPITAL



100% OF THE SCAVENGE CONFERENCE, INC.

100% OF THE SCAVENGE CONFERENCE, INC.

013077

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8600026

1

1 - STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST CATHERINE	MIDDLE VICTORIA	LAST DENSMORE	2d DATE OF DEATH January 3, 1986	MONTH YEAR	DAY	YEAR	2b HOUR 11:55 P.M.
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH 8/15/03 DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 72 HRS DAYS HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany							
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE						
13a STATE MARYLAND	13b COUNTY ALLEGANY	13c CITY OR TOWN WOODLAND	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE RT. 1, BOX 268 21532						
14. FATHER'S NAME FIRST THOMAS	MIDDLE 	LAST SIMMERS	15 MOTHER'S MAIDEN NAME FIRST IDA	MIDDLE BELLE	LAST FLEEGLE	ADDRESS 21532 RT. 1, FROSTBURG, MD				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N.A.	17. INFORMANT MRS. BETTY ALLEN, RT. 1, FROSTBURG, MD								
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Congestive heart failure</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
(b) <i>Pulmonary Edema</i>										
(c) <i>Hemera & Gastrointestinal Bleeding</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
<i>List of diabetes mellitus, prev. episodes of congestive heart failure</i>										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Richard Schindler</i>			DEGREE M.D.	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c DATE SIGNED 1-4-86			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard Schindler			22e ADDRESS 69 Greene Street Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		23b. DATE 1/186	23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM PARK	23d. LOCATION CITY OR TOWN FROSTBURG	COUNTY ALLEGANY	STATE MD				
24. FUNERAL DIRECTOR <i>Frankie M. Lewis</i> SOWER'S FUNERAL HOME		25a. ADDRESS 60 W. MAIN ST. FROSTBURG	25a. DATE REC'D. BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death be reported to the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-trust permit. Then please remove completely pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

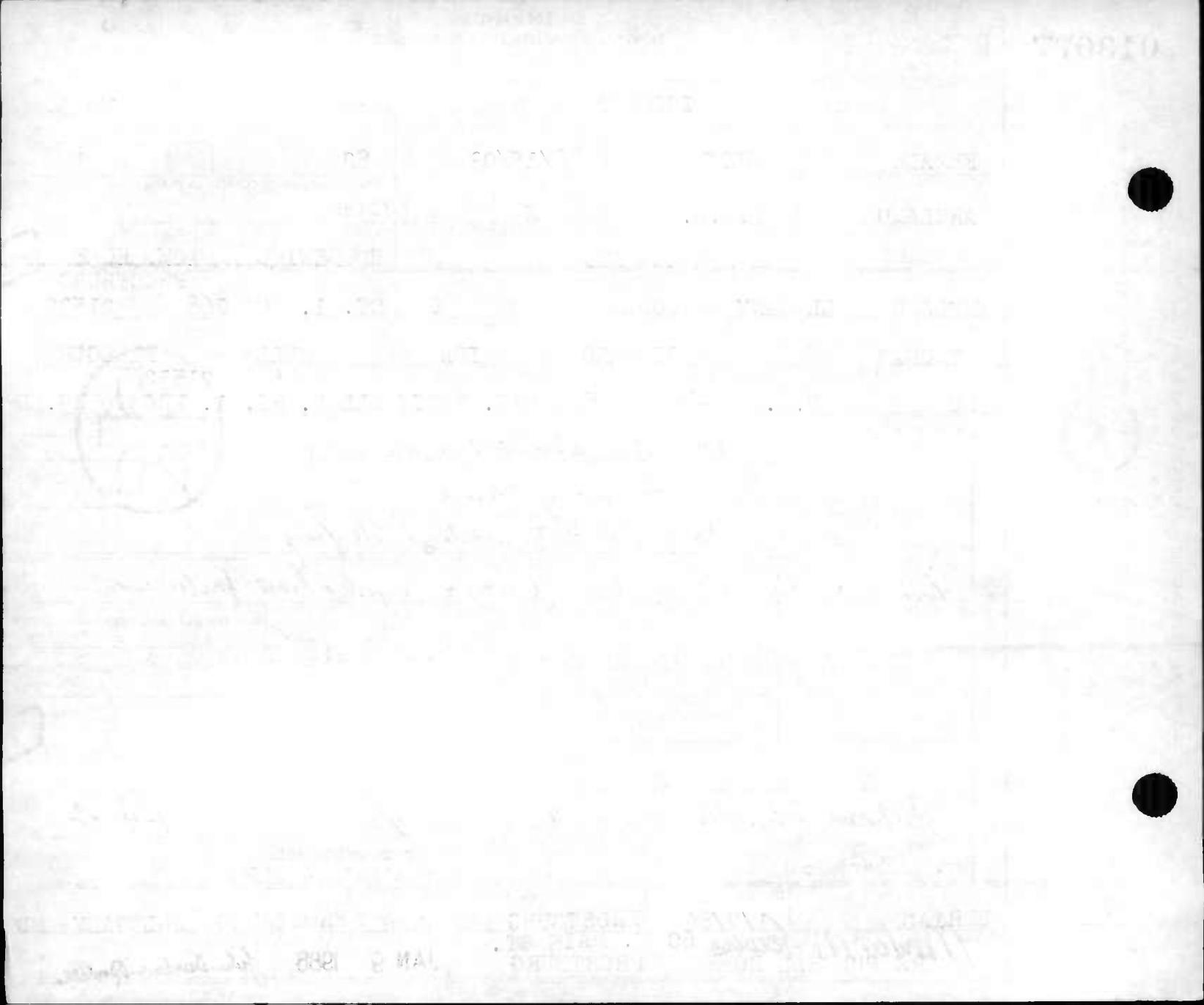


retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove completely pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

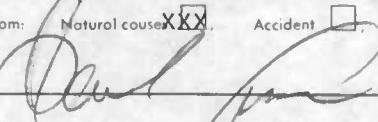
BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)



008183

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 86 00021											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	2b HOUR					
George William Deremer												<input checked="" type="checkbox"/>			1	1	1986	1053A					
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR			
Male		Cau		7 15 17			68 RS.							<input checked="" type="checkbox"/>			1	1	1986	1053A			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?						8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH								
West Virginia			U.S.A.												Allegany								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12e USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b KIND OF BUSINESS OR INDUSTRY								
Cumberland			Memorial Hospital						U.S. Air Force & Kelly-Springfield														
13a STATE West Va			13b COUNTY Mineral			13c CITY OR TOWN Keyser			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS Rt 2 Box 199 / 26726											
14. FATHER'S NAME First			Middle			Last			15. MOTHER'S MAIDEN NAME First			MIDDLE			LAST								
Charles			-			Deremer			Sarah			E.			Daniels								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Military Career			16c. INFORMANT 220-10-7166			17. ADDRESS Ilse D. Deremer-Address same as #13 above														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF												sudden											
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																							
{ (b) Coronary artery heart disease DUE TO, OR AS A CONSEQUENCE OF												years											
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									2d. AUTOPSY?											
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						DATE SIGNED 1-1-86					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS Memorial Hosp. Cumberland Md 21502																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-4-86			23c. NAME OF CEMETERY OR CREMATORIUM Ft. Ashby Cemetery						23d. LOCATION CITY OR TOWN Ft. Ashby-Mineral-West Virginia			COUNTY			STATE					
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A.			ADDRESS									25a. DATE REC'D. BY REGISTRAR JAN 6 1986			25b. REGISTRAR'S SIGNATURE 								
202 Greene Street-Cumberland, Maryland 21502																							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-trust permit. Then please remove carbon from Item 1 and 2. Should the funeral director sign Item 1 and 2, then attach this certificate to the burial-trust permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 2 is marked or Item 11 shows any injury, or other traumatic event, medical examiner shall be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 86 00028	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR January 16, 1986							2b HOUR 12:15 P.M.	
1 DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES		MIDDLE S.		LAST DETRICK					
3. SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 08-22-1920		6 AGE IN YEARS (LAST BIRTHDAY) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.					
10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret. carman		12b KIND OF BUSINESS OR INDUSTRY railroad					
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE WV		13b COUNTY Mineral		13c CITY OR TOWN Ridgeley		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Route 1 Box 184B/26753 99999			
14 FATHER'S NAME FIRST Charles S. Detrick, Sr.		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST Lilly F. Deter MIDDLE		LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. WW II		16c		17 INFORMANT Mrs. Flora M. Detrick, Cumberland, MD -wife		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Marijuana</i> <i>Alcohol</i> <i>MTL</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER CAUSES OF CONDITIONS LEADING UP TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <i>Slightly Nauseated</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED		21e PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, ETC.		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (b) this hospital attended to deceased from <i>Jan 16 86</i> to <i>Jan 15</i> , 19 <i>86</i> , to <i>Jan 16</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (b) did not see the deceased alive on <i>Jan 16 86</i> . (b) saw the deceased alive on <i>Jan 15 86</i> . (b) did not see the body after death.		22b SIGNATURE <i>Terry Williams</i>		22c DEGREE <i>BS</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED <i>1-19-86</i>			
23a PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Terry Williams		23e ADDRESS Memorial Hospital Med. Bldg. Cumberland, MD 21502									
23b BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-19-1986		23c NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a DATE REC'D. BY REGISTRAR JAN 20 1986				25b REGISTRAR'S SIGNATURE <i>Julia Davidson Rodell</i>					
(VRA 15, 4)											

BRUNO

EDS. COLONIALS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove certificate. Item 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other trauma, the event medical examination must be performed before this certificate is issued.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 00029		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR 9:05 M		
BERNICE MARY DEVORE									January 10, 1986					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 09/09/08			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.							
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 214 Oak St. / 21502				
14. FATHER'S NAME FIRST Gilbert		MIDDLE A.		LAST Rohrbaugh			15. MOTHER'S MAIDEN NAME FIRST Addie			LAST Cole				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-12-9279		17. INFORMANT Ina Canada, Box 14, Ellerslie, MD			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>METABOLIC ENCEPHALOPATHY</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> KK YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (We) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (We) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not see the body after death.												22l. DATE SIGNED 1/10/86		
22b. SIGNATURE Dr. Amado Torres		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/86		23c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cem.			23d. LOCATION CITY OR TOWN RD, Hyndman, Bedford, PA			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Harvey H. Feigler ADDRESS Hyndman, PA		25a. DATE REC'D. BY REGISTRAR JAN 14 1986		25b. REGISTRAR'S SIGNATURE Julia L. Jordan Pendell										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remember to file a copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 shows any injury, or other condition, indicate it on the back of this certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8600030											
												REG. NO.											
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
1 DECEASED NAME (TYPE OR PRINT)			Anna						Digioia			1	13	86	7:45 AM								
3. SEX		4 RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	IF UNDER 24 HRS									
Female		White		MONTH 9			DAY 10			YEAR 06			79	YRS.	MONTHS	DAYS	HOURS	MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.										
Maryland		U.S.A.											Alegany County										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY													
Frostburg		Frostburg Community Hospital		Teacher						School													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
												Maryland				Allegany		Luke				339 Fairview St., 21540	
14. FATHER'S NAME		FIRST		LAST			15. MOTHER'S MAIDEN NAME			FIRST		LAST											
		John		Eagan			Agnes					O'Neil											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS													
No				217-30-2089			Mary K. Gardner, Silver Spring, Md.			2613 Redmiles Dr.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Cardio Respiratory Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Septicemia				3 days							
(b)																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Dialysis Ketoacidosis. old age.											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED											
22b. SIGNATURE <i>S. Lal Sandhir</i>												22c. DATE SIGNED 1/13/86											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
S. Lal Sandhir		48 Tarn Terrace			MD						21532												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY/TOWN			23e. COUNT													
Cremation		Jan. 14 '86		Smithsburg Crematory			Smithsburg, Md.																
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE															
Durst Funeral Home, Frostburg, Md.					JAN 20 1986			<i>John Wilson Pendleton</i>															
DHMH - 16 60M 7/84 (VRA 15, 4)																							

WILSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

020061

Hafer Funeral Home
FOR STATE 1302 National Hwy
REGISTRAR Lavale, MD 21502STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00031

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Otto					Drooge	January 10, 1986				2:45A _M	
1. SEX Male		4. RACE White		5. DATE OF BIRTH 10TH 3- 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11. STREET ADDRESS / ZIP CODE 214 Park St 21502					
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland							
14. FATHER'S NAME (FIRST) (Unknown)		MIDDLE		LAST Drooge		15. MOTHER'S MAIDEN NAME Catherine		MIDDLE		LAST Rust	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 705076819		17. INFORMANT Ruth E. Drooge--same as above		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for part I, II, and III.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive Heart Failure									
		Approximate interval between onset and death days									
		DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)									
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Syrup of ipecac was given											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		19 10 86		19 10 to 19 10 86		19 10 86		19 10 86		19 10 86	
above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Renato Espina, M.D.</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Renato Espina, M.D.		907 Seton Drive Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 12, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial		23d. LOCATION CITY OR TOWN Cumberland, Alleg., Md.		23e. COUNTY Alleg.		STATE Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr		LaVale, Md 21502				25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

024156

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18a. THE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM2. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 WASHINGTON STREET,

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00032			
1. DECEASED NAME (TYPE OR PRINT) Virginia Madeline Eaton												2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 13 19 86 2306			
3. SEX Female 4. RACE Cau 5. DATE OF BIRTH MONTH DAY YEAR Dec 21 1898 6. AGE (IN YEARS LAST BIRTHDAY) 87 yrs.												2b DATE PRONOUNCED DEAD MONTH DAY YEAR 1 13 19 86 2306a			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia 7b CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												9. BALTIMORE CITY OR COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Cumberland 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital												12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postmistress 12b KIND OF BUSINESS OR INDUSTRY U.S. Mail			
13a STATE West Virginia 13b COUNTY Morgan 13c CITY OR TOWN Paw Paw 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												13e STREET ADDRESS Route 1 Box 33			
14. FATHER'S NAME FIRST Charles MIDDLE LAST Whisner 15. MOTHER'S MAIDEN NAME FIRST Ollie MIDDLE LAST Henry															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 233-40-9327 17. INFORMANT Mr. James W. Parr Paw Paw, W.Va.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 888 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Aortic stenosis												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 1 hour years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Fracture left clavicle, 30 hours															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1400hrs 1/12 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) patient fell at home							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET Box 33 CITY OR TOWN Paw Paw COUNTY West Virginia STATE							
22a. I certify that took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Paul Snow</i>															
23a. EXAMINER'S NAME (TYPE OR PRINT) Paul Snow, M.D.												TITLE (SPECIFY) M.D. MEDICAL EXAMINER			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23c. DATE 1/16/86				23d. NAME OF CEMETERY OR CREMATORIAL Woodrow Cemetery							
24. FUNERAL DIRECTOR NAME <i>James R. Ryles</i>				ADDRESS <i>Augusta, W.Va.</i>				25a. DATE REC'D. BY REGISTRAR JAN 20 1986							
								25b. REGISTRAR'S SIGNATURE <i>Jane Mandell</i>							

961450

INDUSTRIE

DE LA

X

ALIMENTATION

DU MARCHÉ

DU MARCHÉ

X

VINCENT

PIERRE

CHARLES

SEULEMENT

DU MARCHÉ DE LA CONSOMMATION

F529-08-555

PARIS COMMERCIAL

CD



DU MARCHÉ DE LA CONSOMMATION

PARIS COMMERCIAL

1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

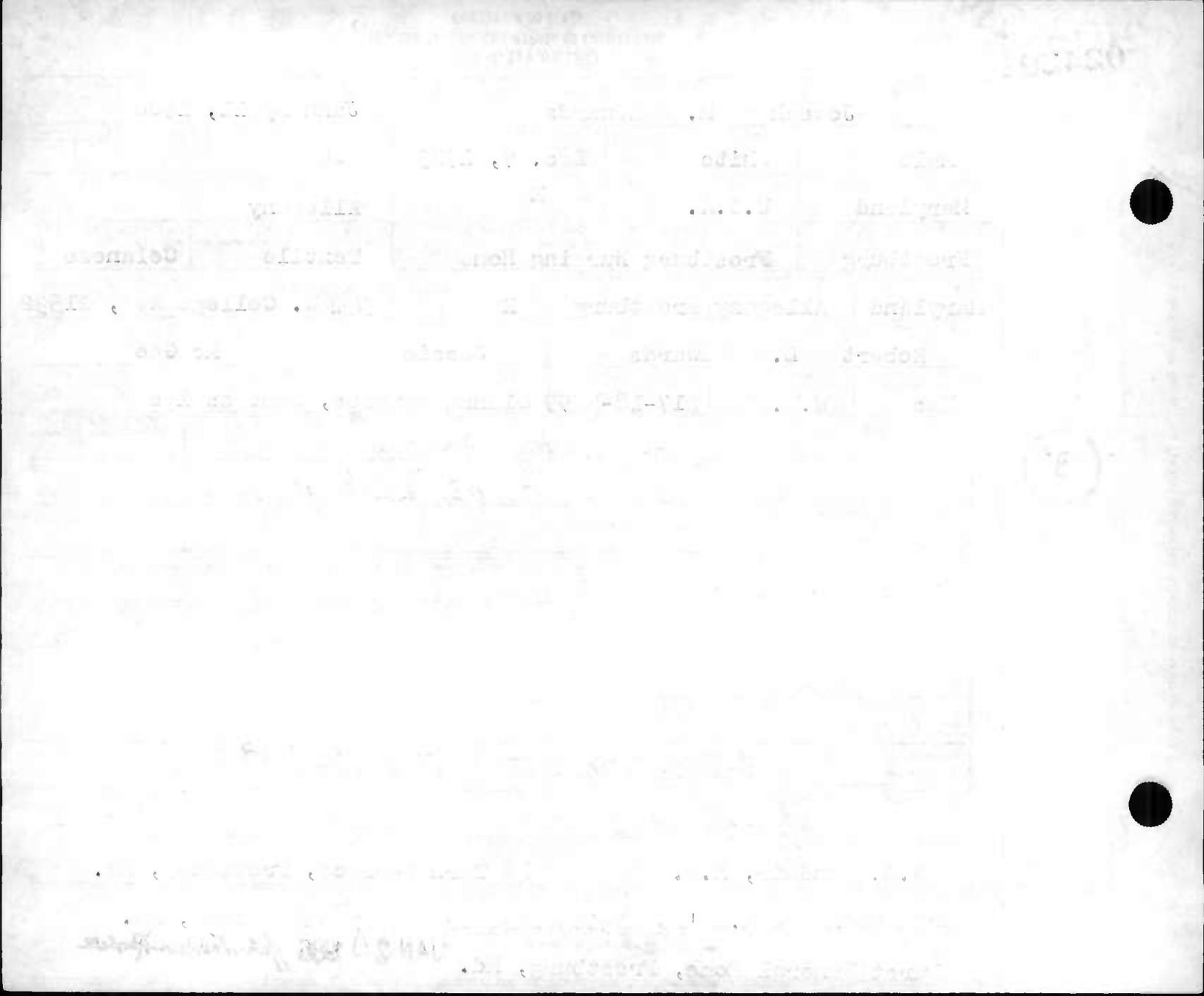
024201

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B6 00033

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Joseph M. Edwards						January 11, 1986					
3. SEX		4 RACE	5. DATE OF BIRTH								
Male		White	Month	Day	Year						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Allegany					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Frostburg		Frostburg Nursing Home			Textile			Celanese			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Allegany	Frostburg			34½ W. College Ave, 21532					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		Robert	L.	Edwards			Jessie		Mc Gee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) If YES, GIVE WAR OR DATES		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		W.W. 2		217-18-4499		Glenna Edwards, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD and Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute Respiratory infection</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> to <u>1/11/1986</u> 19, that (I) (we) last saw the deceased alive on <u>Dec 18 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (he) (she) (did not) view the body after death.											
22b. SIGNATURE <u>S.L. Sandhir</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>1/13/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S.L. Sandhir, M.D.</u>		22e. ADDRESS <u>48 Tarn Terrace, Frostburg, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 12 '86		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg, Md.		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS JAN 20 1986		25. DATE RECEIVED BY REGISTRAR JAN 20 1986		26. REGISTRAR'S SIGNATURE <u>Jeanne L. Sandhir</u>					



009062

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED IN FULL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ACCORDING WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRACTOR PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR INCINERATION.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00034	
1 - STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)						2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 1 MONTH 15 DAY 5 YEAR 86 HOUR 16 M					
		FIRST		MIDDLE		LAST		2b DATE PRONOUNCED DEAD <input type="checkbox"/> MONTH 1 MONTH 15 DAY 5 YEAR 86 HOUR 1530 M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
Female		Cau		03-29-1899		86 yrs.							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany			
PA		USA								MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Cumberland		208 Fairfax Street						housewife		own home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 208 Fairfax Street 21502					
Maryland		Allegany		Cumberland									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME					
		John Bolbach						Susanna Frinafrock					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		ADDRESS			
no		212-74-4013						Charles R. & Wm. J. Evans, Cumberland, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF												sudden	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>													
{ (b) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF												minutes	
(c) <u>Cardio-vascular heart disease</u>												years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
Chronic renal failure; recent sepsis under treatment													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 15/86	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Dpty						MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Memorial Hosp. Cumberland Md 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		01-08-1986		Sunset Memorial Park		Cumberland		Allegany		MD			
24. FUNERAL DIRECTOR		NAME James F. Scarpelli, Cumberland, MD 21502						25a. DATE REC'D. BY REGISTRAR JAN 8 1986		25b. REGISTRAR'S SIGNATURE			

270620

AMERICA



AMERICAN LIBRARIES

020080

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER **BP** AG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00035

1-
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
LILLIE			MARIE		FLETCHER	<input checked="" type="checkbox"/>			1	8	1986	9:15 M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Female	Cau.	9 15 08	77	YRS.		<input checked="" type="checkbox"/>			1	8	1986	10:30 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Penns.		USA							Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		537 Eastern Ave.			Housewife			Home					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Md.		Allegany	Cumberland		<input checked="" type="checkbox"/>			537 Eastern Ave. 21502					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST				
Joseph			Owen	Shipley	Clara			Virginia	Shaffer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No		214-05-9876-B			Mrs. Shirley Wigfield			R# 9 Box 293 Williams Rd. Cumb.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) <i>Disease</i> , DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY) <i>Francisco Reyes M.D.</i>			MEDICAL EXAMINER			DATE SIGNED <i>1-8-86</i>					
EXAMINER'S NAME (TYPE OR PRINT)		<i>Francisco Reyes</i>			ADDRESS <i>900 Seton Dr. Cumberland Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		1-10-86		Hillcrest Burial Park			Cumberland Allegany Md.		22902				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Silcox-Merritt Funeral Home - Cumberland MD					JAN 13 1986			Julia D. Johnson-Pendell					

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HAFER FUNERAL HOME

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8600035

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR						
			CYRUS	Edwin	FRANKENBERRY	JANUARY 13, 1986			2:25P M							
3. SEX			4 RACE	5. DATE OF BIRTH												
Male			White	July 11, 1900	MONTH DAY YEAR	16 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12b KIND OF BUSINESS OR INDUSTRY Celanese		
13a STATE Maryland			13b COUNTY Allegany	13c CITY OR TOWN Mt. Savage	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE Route 1, Box 88 / 21545			14 FATHER'S NAME Thomas L. Frankenberry			15 MOTHER'S MAIDEN NAME Dortha Miller				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	18a APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			16c ADDRESS Virginia Crump - Mt. Savage, MD								
No			214075596													
18b CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			<i>Septicemia</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			{ (b) <i>Pneumonia</i>													
{ (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF { (c) <i>Renal failure C.U.T.E.</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input type="checkbox"/>							YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (i) this hospital attended the deceased from <i>Jan 13</i> , 19 <i>86</i> to <i>Jan 13</i> , 19 <i>86</i> , that (ii) we last saw the deceased alive on <i>Jan 13</i> , 19 <i>86</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (ii) (iii) did not view the body after death.		22b. DEGREE <i>Chang Oh, M.D.</i>		22c. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>1/14/86</i>		22e. ADDRESS 48 TARN TERRACE FROSTBURG, MD. 21532							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 16, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Savage Meth. Mt. Savage, Alleg., MD			23d. LOCATION CITY OR TOWN COUNTY STATE		25a. DATE REC'D. BY REGISTRAR JAN 17 1986		25b. REGISTRAR'S SIGNATURE <i>John Hafer Jr.</i>					
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, MD														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove this page and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ANNUAL REPORT

ANTONIO VIANELLA

Ms. B. 12. 2. 19

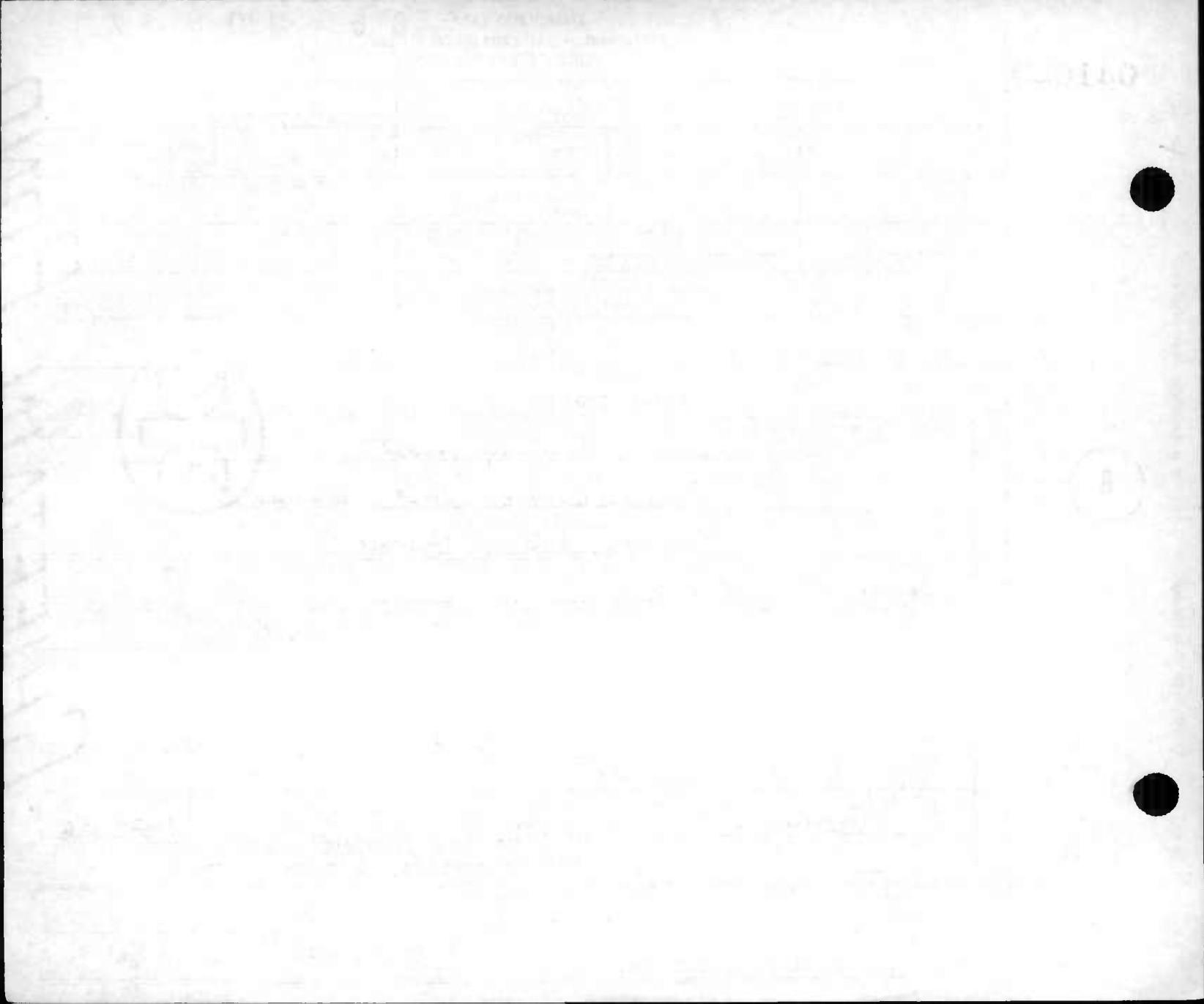
10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to you as the funeral director. Then please return it to the State Board of Health and Mental Hygiene Office No. 2, Baltimore, or remit with the State Dept. of Health and Mental Hygiene, 600 St. Paul Street, Baltimore, Maryland 21201. It is important that Item 21 be filled in immediately after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	0	0	0	3	1								
										REG. NO.														
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH		DAY		YEAR		2b HOUR			
(TYPE OR PRINT)			MICHELE			FRANZE						JANUARY 27, 1986									11:25A.M.			
3. SEX		4 RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS								
male		white		MONTH 01			DAY 02		YEAR 1886		100 YRS			MONTHS			DAYS			HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.										
Italy		USA									Allegany													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
CUMBERLAND		MEMORIAL HOSPITAL								ret. trackman			railroad											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE														
MD		Allegany		Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			313 South Cedar Street/21502														
14. FATHER'S NAME		FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME													
		Natale			Franze						Catherine Seminara													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																
no		705-09-7044			Mrs. Frances Franze, Cumberland, MD - wife																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>																								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriovenous fistula disease</i>																								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
Lower GI bleeding																								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
19a.										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
		HOUR A.M. MONTH DAY YEAR			P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (I) (this hospital) attended the deceased from											1-25-86			to 1-27-86										
saw the deceased alive on 1-27-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																								
22b. SIGNATURE					DEGREE						MD			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED	
														<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			1-29-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)											MEMORIAL HOSPITAL MEDICAL BUILDING													
DR. BARRERA											CUMBERLAND, MARYLAND 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION			CITY OR TOWN			COUNTY			MD								
Burial		01-30-1986		St. Patricks Cemetery						Cumberland			Allegany											
24. FUNERAL DIRECTOR		NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			FEB 03 1986			25b. REGISTRAR'S SIGNATURE										
		James F. Scarpelli, Cumberland, MD 21502																						



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL VISIT REPORT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 20TH & SETON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00038		
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) ANNA FRANCES FREE									2a DATE KNOWN OF ESTI- DEATH MATED 01-19 1986		
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH 06 DAY 11 YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0		2c. DATE PRONOUNCED DEAD 01/19/1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany						
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital & Medical Cent.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 109 Grand Avenue/21502						
14. FATHER'S NAME FIRST Homer			MIDDLE Golliday			LAST			15. MOTHER'S MAIDEN NAME FIRST Carrie Frye					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-46-3564			17. INFORMANT Miss Norma J. Free, Cumberland, MD-daughter			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8842 IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia and Congestive failure DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Fracture of Hip (right)														
19a. DATE OF OPERATION 01/17/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Right Hip			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 am 1/17/86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Fell from Bed in the Hospital								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) Hospital			21f. LOCATION STREET Memorial Ave. CITY OR TOWN Cumberland, Md. COUNTY Allegany STATE Md.								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i> TITLE (SPECIFY) Giovanni Mastrangelo, M.D. Deputy MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT) Giovanni Mastrangelo, M.D. ADDRESS 912 Seton Drive, Cumberland, MD												DATE SIGNED 1/14/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 01-22-1986			23c. NAME OF CEMETERY OR CREMATORIAL Hawkinsontown UME Cem.			23d. LOCATION CITY OR TOWN Hawkinsontown COUNTY Allegany STATE VA					
24. FUNERAL DIRECTOR NAME James F. Scarpelli			ADDRESS Cumberland, MD 21502			25a. DATE REC'D. BY REGISTRAR JAN 27 1986			25b. REGISTRAR'S SIGNATURE <i>Suzanne Pendleton</i>					

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FOR SILCOX-MERRITT FUNERAL HOME 1 - STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR 404 DECATUR ST. CUMB.MD. CERTIFICATE OF DEATH				STATE OF MARYLAND 3 6 0 0 0 3 9									
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR					
	GRACE	REBECCA	TWIGG GALL	JANUARY 21, 1986				5:45PM					
3. SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
FEMALE	WHITE	MONTH	DAY	YEAR	87	YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND	USA				ALLEGANY COUNTY			MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
CUMBERLAND	SACRED HEART HOSPITAL		HOUSEWIFE										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE MARYLAND				13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE OLDTOWNE MANOR OLDTOWN ROAD 21502		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							LAST		
WILLIAM			KITZMILLER	IDA							ROSENMERKLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			WILMINGTON,					
NO	220-16-5492 D		ROBERT TWIGG 4905 LORD BYRON ROAD NORTH CARLINA										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Cardio-Respiratory Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Post-Cardiac arrest				Suddenly					
{				(c) Post-Pulmonary Embolism.				{					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a acute aspiration pneumonia. Syphi. Urinary infection - Diabetes. Post CVA.													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED <small>WHILE AT HOME AT WORK NOT WHILE AT WORK</small>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/21/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				1/11, 1986, to 1/21, 1986									
22b. SIGNATURE SIKANDER SANDHIR, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF <input type="checkbox"/>	22c. DATE SIGNED 1/22/86								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS 48 TARN TERRACE FROSTBURG, MD. 21532												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN 24 1986	23c. NAME OF CEMETERY OR CREMATORIUM GREENMOUNT CEMETERY	23d. LOCATION CUMBERLAND ALLEGANY MARYLAND										
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND	25a. DATE REC'D. BY REGISTRAR 27 1986				25b. REGISTRAR'S SIGNATURE Julie Sandhir, R.N.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed and completely filled in by the funeral director; page 3 should be detached for use as the burial permit. These places can be used if 1 and 2 should be used within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. This place can be used if 1 and 2 should be used within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other significant event, the medical examiner will be notified and informed.

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031113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86	00040		
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
REGINA C. GELLNER						JANUARY 25, 1986						12:15P M			
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			
Female			White			July 28, 1903						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.										Allegany MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cumberland			Altégany County Nursing Home			HOMEMAKER			Home						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Allegany		Cumberland					719 Washington Street / 21502					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Joseph			F.	Carbine	Mary			-	Carney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			214-05-8824			Rosemary C. Hill			719 Washington St. Cumberland, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sepsis</i>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>AS CVD. Dementia Thg to cerebral Atrophy</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11 - 24 19 80 to 1 - 25 19 86, that (II) (we) last saw the deceased alive on 11 - 24 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>V. A. Ranjithan.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-25-86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VIMALA A. RANJITHAN.</i>			22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-27-86			23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.			23d. LOCATION CITY OR TOWN Cumberland-Allegany Co., MD.						
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 29 1986			25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendleton</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

020237

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification must be completed and filed with this certificate.

SHAFFER FUNERAL HOME 230 E MAIN STREET ROMNEY, WV 26757			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					86 00041							
1 - FOR STATE REGISTRAR								REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Hester Ann Glaze						January 9, 1986						1:10A M			
3. SEX			4. RACE		5. DATE OF BIRTH		16. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White		MONTH DAY YEAR June 6, 1906		79			MONTHS	YEARS	MONTHS	HOURS MIN.		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U.S.A.				Allegany County,								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			Sacred Heart Hospital					Housewife			Home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			99999 26722			
WV			Hampshire		Greenspring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	Robinson			
Pent			Z		Kerns	Sarah			Etta						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> NO			16b. SOCIAL SECURITY NO. 234623929			17. INFORMANT			ADDRESS WV 26753			Beatrice Whitacre, Rt. 2, Box 479, Ridgeley,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malfunction of Pace maker. (c) Right lower lobe pneumonia.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-30, 1985, to 1-9, 1986, that (I) (we) last saw the deceased alive on 1-8, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Uriel Velandia, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1-9-86						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Uriel Velandia, M.D.			22f. ADDRESS 924 Seton Drive, Cumberland, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/12/86			23c. NAME OF CEMETERY OR CREMATORIAL Forest Glen Cemetery			23d. LOCATION CITY OR TOWN Greenspring			STATE Hampshire WV			
24. FUNERAL DIRECTOR NAME Keith S. Shaffer ADDRESS Shaffer Funeral Home, Romney, WV 26757						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						

BP
999999
DHMH 1650M 4/83
(VRA 15, 4)

2001 JASPER ROAD
TRAILER PARK
CITY OF CALGARY

UNIT 1001 VILLENEUVE

EXCERPT

1001 VILLENEUVE

VILLENEUVE

Testimony about Arson

EXCERPT

2001 JASPER ROAD TRAILER PARK UNIT 1001 VILLENEUVE

TESTIMONY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

reduced by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then please return certificate pages 1 and 2 to the funeral director. The burial permit will be sent with the State Dept. of Health and Mental Hygiene either to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner may be called upon to examine the deceased.

041038

Durst Funeral Home

57 Frost Ave
Frostburg, MD 21532STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 4 2

1. FOR
STATE
REGISTRAR

REG NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			Walter	Aloysius	Grahame	January 23, 1986				10:18PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male		White		January 31, 1905		80							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD					
Maryland		U.S.A.				Allegany County,							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Cumberland		Sacred Heart Hospital						Auditor					
12b. KIND OF BUSINESS OR INDUSTRY													
Race Track													
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. ADDRESS						
Maryland	Allegany	Cumberland			631 Columbia Ave., 21502		829 Columbia Ave						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS						
		John	Colin	Grahame	Margaret		Paul Miller, Cumberland, Md. 21502						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		166090535		Paul Miller, Cumberland, Md. 21502		10 mn							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac arrhythmia</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>													
10 d													
YEAR													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
<i>Precardiac arrest</i> <i>Cord</i> <i>Prostatic Hypertrophy</i> <i>senility</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19c. DATE OF OPERATION						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE				22d. ATTENDING PHYSICIAN		22e. MEDICAL DIRECTOR		22f. STAFF PHYSICIAN		22g. DATE SIGNED	
Victor E. Mazzocco, M.D.												1-28-86	
22h. PHYSICIAN'S NAME (TYPE OR PRINT)		22i. ADDRESS				22j. ADDRESS							
Victor E. Mazzocco, M.D.		BMG, 912 Seton Drive, Cumberland, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		Jan. 27 1986		St. Michaels Cem.		Frostburg, Allegany, Md.							
24. FUNERAL DIRECTOR NAME													
Durst Funeral Home, Frostburg, Md.													
25a. DATE RECD. BY REGISTRAR													
FEB 03 1986													

6. **What is your name?** **John Edward Morris**
What is your address? **1000 N. 1st Street, Suite 500, Sacramento, CA 95834**
What is your telephone number? **(916) 445-1234**

103 *Tony Le Vian*, *art*

UK Tech News

014008

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00043

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			Rhoda C. Dayton Gross			Jan. 4			1986	12:30	P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		July 6, 1901		84			MONTHS DAYS		YEARS
7a BIRTHPLACE (STATE OR FOREIGN)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOTE SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Pinto		Maple Lane		Housewife			In Own Home				
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		MD. 21656	
Maryland		Allegany		Pinto				Maple Lane			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			ADDRESS				
		Norman S. Yoder		Annie Yoder			Daughter				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			Mrs. Virginia D. Moreland, Pinto, Md.				
no		236-58-0889									
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Ventricular Arrhythmia											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) <input type="checkbox"/> my physician attended the deceased from Dec 22, 1985, to Jan 4, 1986, that (I) <input type="checkbox"/> did not see the deceased alive on Jan 4, 1986, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> we <input type="checkbox"/> did not view the body after death.											
22b SIGNATURE Dr. Paul T. Livengood MD		22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED JAN 5 1986							
22e PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul T. Livengood		22f ADDRESS 912 Seton Drive, Cumberland, Md. 21502									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-7-1986		23c NAME OF CEMETERY OR CREMATORIUM Pinto Cemetery		23d LOCATION CITY OR TOWN Pinto, Allegany, Md. COUNTY STATE					
24 FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, Md. 21502		25a DATE REC'D. BY REGISTRAR JAN 8 1986		25b REGISTRAR'S SIGNATURE Julia Swanson Pendleton							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other immobile event, the medical examiner must be notified.

029033

STATE OF MARYLAND R 6 00044
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE
REGISTRAR

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1 & 2 AND 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, BURIAL TRANSIT PERMIT. PAGES NAME & ADDRESS FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DECEASED NAME (TYPE OR PRINT)		FIRST <i>Murray</i>	MIDDLE <i>Leonard E.</i>	LAST <i>Grouden</i>	2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 24 1986	2b. HOUR 18:29 M
3. SEX <input checked="" type="checkbox"/> M	4. RACE <input checked="" type="checkbox"/> W	5. DATE OF BIRTH MONTH DAY YEAR 1 28 13	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 24 1986	2d. HOUR 18:29 M
7a. BIRTHPLACE (NAME OF FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Allegany</i>	
10. CITY OR TOWN OF DEATH <i>Cumberland</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Clerk</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Rail Road</i>	
13a. STATE <input checked="" type="checkbox"/> Penna	13b. COUNTY <input checked="" type="checkbox"/> Bedford	13c. CITY OR TOWN <input checked="" type="checkbox"/> Bedford	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	13e. STREET ADDRESS <i>Rt. # 3</i>	999999	15522
14. FATHER'S NAME FIRST <input checked="" type="checkbox"/> John		MIDDLE <input checked="" type="checkbox"/> Ewing	LAST <input checked="" type="checkbox"/> Grouden	15. MOTHER'S MAIDEN NAME FIRST <input checked="" type="checkbox"/> Myrtle	MIDDLE <input checked="" type="checkbox"/> Bell	LAST <input checked="" type="checkbox"/> Rice
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. <i>705-10-7323</i>		17. INFORMANT <i>Maxine Sweitzer</i>	ADDRESS <i>Cumberland, MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> } (b) <i>Arteriosclerotic Heart disease and</i> <i>calcific Aortic stenosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Francisco Reyes</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>		MEDICAL EXAMINER DATE SIGNED 1-24-86		
EXAMINER'S NAME (TYPE OR PRINT) <i>Francisco Reyes</i>		ADDRESS <i>900 Seton Dr. Cumberland, Md 21502</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> Burial		23b. DATE <i>Jan. 28, 1986</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Centenary Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>William G. Kight</i>		ADDRESS <i>Cumberland, MD</i>	25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>JAN 27 1986</i>			

Mar 18, 1989 California Competing With
Millions Of Kids Competing In

100-10-1333 Mexico's sweater Competing, MD

Japan made China Mexico
Rico
Perry
Gordon
Hartie
Petri
Tuna
Fernandez
Bogotan
X No. # 3 12223

Reg. Clerk City Song

Altadena

ABU

Perry

022126

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN SECTION ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL AUTHORIZATION PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RE-CREATION.

MEDICAL CERTIFICATION

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00045

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	EX MONTH 1 10, 86	DAY YEAR 6:PM	2b. HOUR 2d HOUR
BEATRICE			MAY		HARDEN				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH 1-10	DAY YEAR 1986	2d HOUR 7:15
FEMALE	WHITE	8/18/18	67 yrs.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH		
PENNSYLVANIA		U.S.A.			X		ALLEGANY MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
MORANTOWN		RT. 3, BOX 465, FROSTBURG			HOUSEWIFE		OWN HOME		
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MORANTOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RT. 3, BOX 465, FROSTBURG	21532		
14. FATHER'S NAME FIRST IRA		MIDDLE	LAST KENDALL	15. MOTHER'S MAIDEN NAME FIRST PEARL		MIDDLE	LAST COLLINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N.A.			17. INFORMANT MRS. HILDA GORDON, ECKHART, MD		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Francisco Reyes</i>		TITLE (SPECIFY) M.D. DEPUTY		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 900 Seton Dr. Cumberland Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 1/13/86	23c. NAME OF CEMETERY OR CREMATORIAL PORTER CEMETERY		23d. LOCATION CITY OR TOWN ECKHART		21502 COUNTY ALLEGANY MD STATE		
24. FUNERAL DIRECTOR <i>Merle M. Sowers</i> SOWERS FUNERAL HOME		60 W. MAIN ST.		25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Fairman, Reg. No. 100045</i>			
BP		FROSTBURG							
DHMH - 17 (VR A15 ME (5))									

331530



014009

BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT INTRUMENT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 00046						
1- STATE REGISTRAR		Francis Emil Haselberger						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR Jan. 1, 86				2b. HOUR M				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2c. DATE ESTI- DEATH MATED <input checked="" type="checkbox"/> Jan. 1, 86				2d. HOUR 5P M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 76		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD Jan. 3, 86				7d. HOUR 5P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany										
10. CITY OR TOWN OF DEATH La Vale		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 1, Box 23, Gramlich Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk				12b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Dept.				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 23, Gramlich Road								
14. FATHER'S NAME FIRST Joseph		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Mary Mc Kenna		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-5383		17. INFORMANT Mrs. Constance Smith, Clarksville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Cardiac Arrest										
IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		DUE TO, OR AS A CONSEQUENCE OF Cardiac Arrhythmia		(b) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes: High Blood Pressure										Years						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										23. TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) Paul Snow M.D.										DATE SIGNED Jan. 3, 1986						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-6-1985		23c. NAME OF CEMETERY OR CREMATORIAL SS-Peter & Paul Cemetery		23d. LOCATION CITY/TOWNSHIP Cumberland, Allegany, Md.		25a. DATE REC'D. BY REGISTRAR JAN 8 1986				25b. REGISTRAR'S SIGNATURE John J. Scarpelli				
24. FUNERAL DIRECTOR NAME James F. Scarpelli		ADDRESS Cumberland, Md. 21502														

022077

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "TRADING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL Cremation, or Removal

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00041			
1- STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED				2b. HOUR 6:00 A.M.			
Floyd		Nathan		Hill		XX 1 14 1986									
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR. MONTHS	8 IF UNDER 24 HRS. DAYS HOURS MIN	2c. DATE Pronounced Dead				2d. HOUR 10:30 A.M.					
MALE	WHITE	MAY 20 1920	65 yrs			XX 1 14 1986									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED XX				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		RFD#8 CHRISTIE ROAD				RETIRED AUTO BODY SHOP EMPLOYEE									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS					
MARYLAND		ALLEGANY		CUMBERLAND		XX RFD# 8 CHRISTIE ROAD BOX 123									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST				MIDDLE		LAST			
BRETHARD				HILL		BEULAH				ELLEN		ALABAUGH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
YES		WWII				220-10-7090				JAMES HILL RFD 8 CHRISTIE ROAD CUMBERLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Smoke Inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) Burning of car DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			5:00 A.M. 1-14-86			Car caught on fire									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET off Christie Road						CITY OR TOWN Cumberland	COUNTY Allegany	STATE MD	
			Field												
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 1-14-86			
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy													
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER													
Giovanni Mastrangelo, M.D.		ADDRESS 900 Seton Drive, Cumberland, MD 21502													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
BURIAL			JAN 17 1986			ROCKY GAP VETERANS CEMETERY FLINTSTONE ALLEGANY MD									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD			JAN 17 1986												

70050



041032

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER (LONG BURIAL) OR FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 10 AND 12 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00048											
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b HOUR							
		RAYMOND EVERETT HOWARD									<input checked="" type="checkbox"/>		1	31	1986	6:30A							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d HOUR	
Male		Cau		12/14/12			73 yrs							1/31		19		86		0845			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			7c. DATE OF BIRTH			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH												
OK		USA			12/14/12			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Allegany												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
Cumberland		Rt. 4 Box 202			Oldtown Road			ret.			railroad												
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS															
Maryland		Allegany		Cumberland		YES <input checked="" type="checkbox"/>		Rt. 4 Box 202 Oldtown Road															
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS															
William Virgil Howard						Nancy Elizabeth Haynes		Mrs. Minnie Howard, Cumberland, MD - wife															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
NO		426-07-4040		Mrs. Minnie Howard, Cumberland, MD - wife		IMMEDIATE CAUSE (a) Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) Adenocarcinoma, lung DUE TO, OR AS A CONSEQUENCE OF (c)		sudden															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) Adenocarcinoma, lung DUE TO, OR AS A CONSEQUENCE OF (c)		6 months																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion																		
ACTUAL SIGNATURE					TITLE (SPECIFY)																		
EXAMINER'S NAME (TYPE OR PRINT)		Paul Snow, M.D.			M.D. Dpty MEDICAL EXAMINER																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE													
Burial		02-03-1986		Davis Memorial Cemetery		Cumberland		Allegany		MD													
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																
James F. Scarpelli, Cumberland, MD 21502					FEB 04 1986		John Davidson Pendell																

561140

DATA



022023

GEORGE UPCHURCH FUNERAL HOME

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 0 0 4 9

1. FOR
STATE
REGISTRAR
GREEN STREET
CUMBERLAND, MD 21502

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
GEORGIA			GLADYS	HUMES		JANUARY 7, 1986			11:00AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH DAY YEAR August 18, 1908		77		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U.S.A.				ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL				Buyer		Dept. Store			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 337 Davidson Street / 21502			
Maryland		Allegany		Cumberland							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
John		Whally		Ways		Adelaide		C.		George	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		--		214-05-8354		Ray Humes-315 Frederick St., Cumberland, Md.					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Cardiac Arrest</i>									
887 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease - Angina</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstructive Pulmonary Disease</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Diabetes Mellitus. Fix. Under spine</i>											
19. MEDICAL CERTIFICATION DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED				21a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER FACTORY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c PART I OR PART II)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME STREET, FACTORY, OFFICE, PARK, ETC.				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (b) this hospital attended the deceased from <i>Jan 7, 1986</i> to <i>Jan 9, 1986</i> , saw the deceased alive on <i>Jan 7, 1986</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.											
22b. SIGNATURE <i>Georgia Upchurch</i>		22c. DEGREE M.D.				22d. ATTENDING MEDICAL PHYSICIAN STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>Jan 7, 86</i>			
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS CHANG OH, MD				22h. ADDRESS 48 TARN TERRACE, FROSTBURG, MD 21532					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1 = 9 = 86		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland-Allegany Co.-MD.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street-Cumberland, Md. 21502		25a. DATE REC'D. BY REGISTRAR JAN 20 1986		25b. REGISTRAR'S SIGNATURE <i>George Upchurch</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial/transit permit. It should be filed with the State Dept. of Health and Mental Hygiene for future reference.

IMPORTANT: If item 18 shows any injury, the other traumatic event the medical examiner must be notified at once.

0300000

GEORGE WASHINGTON BRIDGE HOME
GREEN STREET

CHELSEA 1-3260

GEORGIA

CVOCAS

WILCOX

WILLIAMS

WILMINGTON

YELLOWSVILLE

ZURICH FIRM HESSELLER

CHICAGO 10

ZEMLIK TERRACES HESTERSON 24

041048

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

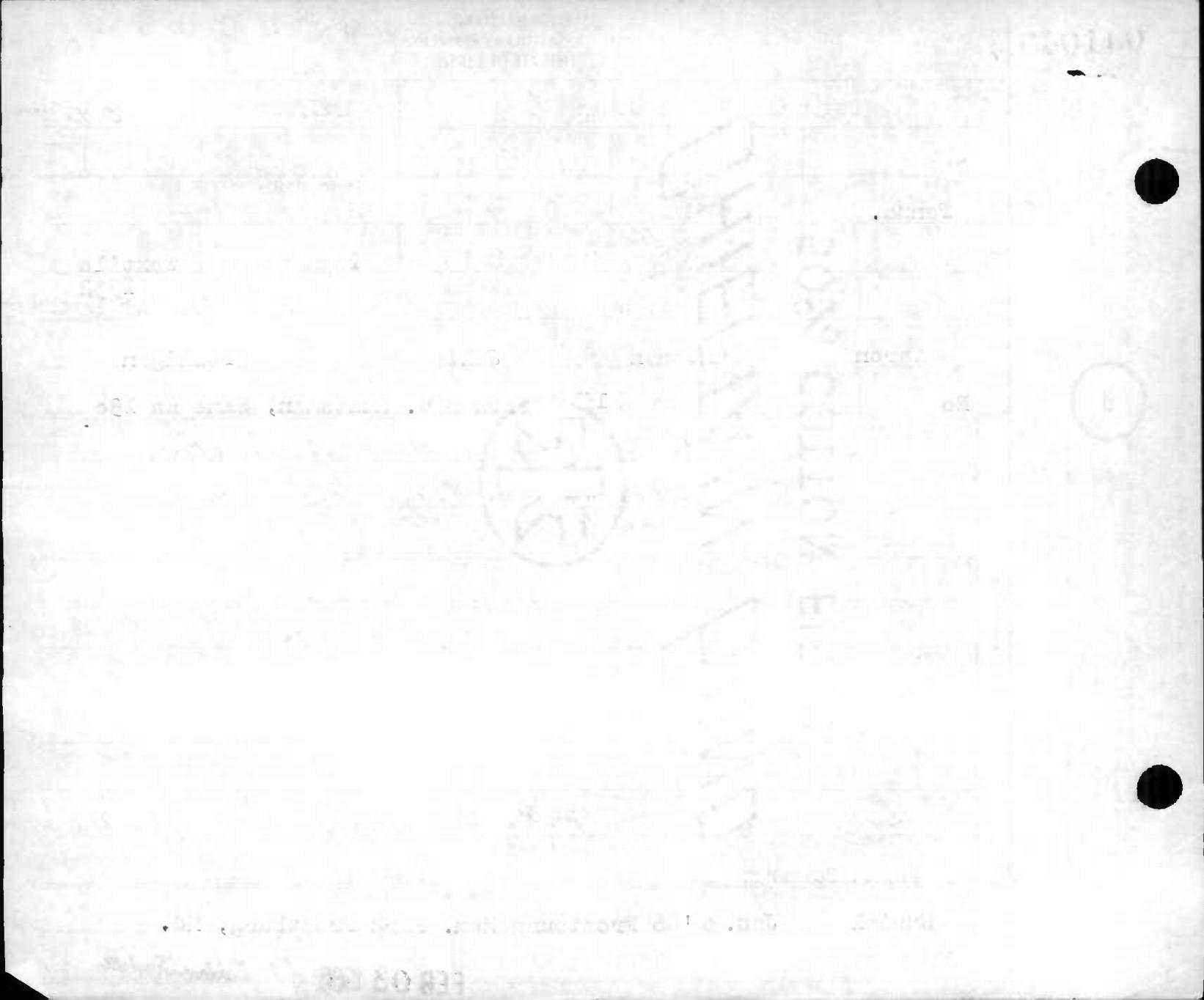
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
			Benjamin	F	Huntsman	1/27/86				10:45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH	DAY	YEAR	85	YEARS	MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Penns.		United States				Allegany MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Frostburg		Frostburg Community Hospital				Paymaster		Textile				
13. STATE		13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21532				
Maryland		Alleg	Frostburg			16 Bowery St., RR#X X X X X Frostburg						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		Aaron		Huntsman			Julia		Pelligan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
No		214 07 1528		Esther O. Huntsman, Same as 13e								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease										
{ DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 		22c. DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 1/27/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				Frostburg, MD 21532						
Dr. S. Schwartz												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE	
Burial		Jan. 30 1986		Frostburg Mem. Park		Frostburg, Md.					FEB 03	
24. FUNERAL DIRECTOR		ADDRESS				Frostburg, MD						
Durst												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached to the death permit. Then please remove carbon paper page 3 and 2 should be attached to the death permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified for live or the thumbprint permit. Then please remove carbon paper page 3 and 2 should be attached to the death permit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00051

031049

REG. NO.

1-
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	XX MONTH DAY YEAR	1b. HOUR 6:17 M	
		Walter	F.	Hymes	<input checked="" type="checkbox"/>	01-17 19 86		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	6:17 a M	
male	white	01-28-1911	74 yrs.		01/17/86	19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MD		USA				Allegany		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		Memorial Hospital			ret. supervisor		textile	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	MD	
MD		Allegany	LaVale			101 Mary Street	21502	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		Margaret A. Senkbeil		
Melvin Lee Hymes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
no		214-07-5057		Lillian M. Hymes, LaVale, MD - wife				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Giovanni Mastrangelo</i>		TITLE (SPECIFY) Deputy M.D.					MEDICAL EXAMINER	
DATE 1-17-1986 SIGNED								
EXAMINER'S NAME (TYPE OR PRINT)		912 Seton Drive, Cumberland Md 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	
Burial		01-21-1986		Zion Memorial Park			COUNTY STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF DEATH JAN 27 1986		Cumberland Allegan MD		
James F. Scarpelli, Cumberland, MD 21502								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE HELD WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 2/80

TO HOSPITAL OR ATTENDING PHYSICIAN. The

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper, pages 1 and 2, from the file 5 weeks/72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

00052

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna NMI Keyes				2a DATE OF DEATH MONTH DAY YEAR 1/ 30/ 86	2b HOUR 10:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 09 82	6. AGE (IN YEARS LAST BIRTHDAY) 83	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.
9. PLACE OF DEATH MD		10. CITIZEN OF WHAT COUNTRY? United States	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD		
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital	12a USUAL OCCUPATION Retired Practical Nurse		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md Allegany Lonaconing		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e BIRTH ADDRESS 291 Furnace St. 21539	12b KIND OF BUSINESS OR INDUSTRY Formerly of	
14. FATHER'S NAME James Russell Mc Intyre		13f MOTHER'S MAIDEN NAME Nellie	13g MIDDLE NAME Russell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE RANK OR DATES) No None		16b SOCIAL SECURITY NO. 220-10-1765	17. INFORMANT Paul Moses Star Rt 1, Box 305 Md Barton,	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Bilateral CVA with marked Contractures					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) (this hospital) attended the deceased from 1980 , to 1986 , that (1) (we) last saw the deceased alive on 1/30/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death					
22b. SIGNATURE S. Lal Sandhir		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Lal Sandhir, M.D.		22e ADDRESS 48 Tarn Terrace Frostburg, MD 21532	22f. DATE SIGNED 1/31/86		
23. BURIAL OR CREMATION REMOVAL SPECIFIC Burial		24. DATE 2-2-86	25. NAME OF CEMETERY OR CREMATORY OAK HILL Cemetery	26. LOCATION Lonaconing Allegany Md	
24. FUNERAL DIRECTOR Eichhorn Funeral Home, Lonaconing, Md.			25a. DATE REC'D. BY REGISTRAR FEB 05 1986	25b. REGISTRAR'S SIGNATURE Wardson Pendell	

W7050

CB SO.

send 1 ticket book

to VFW Post 451

Minneapolis Minnesota

I need

either any type or

please send

noted POF book to next year of just

one

X

if you will kindly write me I will send 20-50 books

and send a book to the minneapolis VFW Post

024200

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT STAMP. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00053	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b HOUR	
MARGARET TWIGG KIDWELL						Ex	1	13	1986			0200	
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR	
Female	Cau	3 28 12	73 yrs			1	13	1986				1640	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U.S.A.						Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Frostburg			54 Ormond Street			Assist Clerk			City				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland	A Allegany	Frostburg	YES <input checked="" type="checkbox"/>			54 Ormond St., 21532							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Noah S. Twigg			Mary Simms										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			214-16-2523			Joan L. Riley, Westernport, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
{ (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF Chronic bradycardia													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE						TITLE (SPECIFY)			DATE SIGNED 1/13/86				
EXAMINER'S NAME (TYPE OR PRINT)			M.D. Dpty			MEDICAL EXAMINER							
Paul Snow, N.D.						Memorial Hosp. Cumberland Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial			Jan. 15 '86			Frostburg Mem. Park			Frostburg, Allegany, Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Durst Funeral Home			Frostburg, Md.			JAN 20 1986			John Durst				

003750

MISSOURI STATE LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

**LEASURE-STEIN FUNERAL HOME STATE OF MARYLAND
230 BALTIMORE AVE. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CUMBERLAND, MD 21502 CERTIFICATE OF DEATH**

86 00054

020057

1. FOR STATE REGISTRAR (TYPE OR PRINT)			LAST			REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
IRENE MARIE KLAUVUHN						01 12 86					8:36 P.M.
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.				
Female			White		11-19-22		63 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.				
West Virginia			U.S.A.								
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY 21502		
13a. STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1804 Holland St. Ext. 21502		
14. FATHER'S NAME Charles Stuart Wilson					15. MOTHER'S MAIDEN NAME Anna Mae UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 215122106		17. INFORMANT Robert C. Klavuhn same as 13a-e.						
No											
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					Cardiac shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost			DOUE TO, OR AS A CONSEQUENCE OF (b) Heart MI								
			DOUE TO, OR AS A CONSEQUENCE OF (c) Coronary heart disease & Peavy arteria n.t.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Stroke											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/12/86, 1986, to 1/12/86, 1986, that (I) (we) last saw the deceased alive on 1/12/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE V. R. FELIPA, M.D.		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/14/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. R. FELIPA, M.D.		22e. ADDRESS 925 BISHOP WALSH ROAD, CUMBERLAND, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1/15/86		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial		23d. LOCATION CITY OR TOWN Cumberland		COUNTY		STATE Allegany MD	
24. FUNERAL DIRECTOR NAME		Leasure-Stein Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE Leasure-Stein Funeral Home, Inc.			
220 Baltimore Ave. Cumberland, MD 21502											

TC00030

LEADER-TECH INC.
230 DULITMORE AVE.
CUMBERLAND, MD 21020

DATE NAME DATE

MAILED BY COUNTRY

SCOTTISH HIGHLANDERS

30103100

100 LINDENWOOD, CUMBERLAND, MD

W. R. FETTER, MD

016044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to the State Dept. of Health and Mental Hygiene, it may be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 5 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 6 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 7 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 8 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 9 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 10 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 11 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 12 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 13 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 14 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 15 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 16 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 17 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 18 shows any injury or other traumatic event before death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event before death,

MEDICAL CERTIFICATION

1. STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 0 0 5 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR	
			ELIZABETH	A	LAMBERT	January 9, 1986				A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH	DAY	YEAR	60	MONTHS	YEARS	MONTHS	YEARS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD			
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Allegany		Domestic House			
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
Cumberland						Memorial Hospital					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE					
Maryland		Allegany		Westernport		Rt. 1 Box 143 21562					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
Frank				Ravenscroft		Agnes			Riley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
no			215-42-2504			Mr. Lewis Lambert			Same		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Cardio-respiratory failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) Congestive Cardiac failure.											
DUE TO, OR AS A CONSEQUENCE OF c) Congestive Cardiac failure.											
DUE TO, OR AS A CONSEQUENCE OF d) Congestive Cardiac failure.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 1985 to <u>1/9</u> 1985 that (I) (we) last saw the deceased alive on <u>1/8</u> 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Dr. Shrestha									1/9 '85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Dr. Shrestha						Memorial Hospital Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN STATE		
Burial			1/11/86			Duckworth Cemetery			Westernport Allegany Md. State		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR					
Boals Funeral Service Westernport Md.						JAN 13 1986					
						25b. REGISTRAR'S SIGNATURE					

other : 2

TO HOSPITAL OR ATTENDING PHYSICIAN. The
retained by the hospital or attending physician.

date be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then pages 1 and 2 should be filed within 72 hours after death with the State Board of Health and Mental Hygiene office or funeral director's office.

with the State Dept. or Health and Mental Hygiene prior to publication.

Medical Record Books at once

45

IMPORTANT JUDGEMENTS

M 7/B4

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO

020234

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
MARGUERITE BELL LANTZ						January 8, 1986				3:45 AM
3. SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH OCT 18 1896			6. AGE (IN YEARS LAST BIRTHDAY) 89	IF UNDER 1 YEAR MONTHS YRS		# UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W.VA.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany					MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a USUAL OCCUPATION CELANESE CORP OF AMERICA			12b KIND OF BUSINESS OR INDUSTRY 99999			
13a STATE W.VA.	13b COUNTY MINERAL	13c CITY OR TOWN RIDGELEY	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE RFD# 1					
14 FATHER'S NAME SAMPSON	FIRST MIDDLE DAY	LAST	15. MOTHER'S MAIDEN NAME LOTTIE		MIDDLE LAST GIBSON					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO 235-32-7176	17. INFORMANT MARGARET VIANDS RFD 1 WILEY FORD W.VA.	ADDRESS							
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/18/86</i> , 19 <i>86</i> , to <i>1/8/86</i> , 19 <i>86</i> , that (I) (we) lost sow the deceased alive on <i>12/18/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>P. L. Haimos</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>1/8/86</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Peter Haimos	22e. ADDRESS Memorial Hospital & Medical Center Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JAN 10 1986	23c. NAME OF CEMETERY OR CREMATORIAL REST LAWN CEMETERY	23d. LOCATION CITY/TOWN LAVALE ALLEGANY MARYLAND	23e. COUNTY ALLEGANY		23f. STATE MARYLAND				
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND	ADDRESS	25a. DATE REC'D. BY REGISTRAR JAN 13 1986 25b. REGISTRAR'S SIGNATURE <i>Silcox-Merritt Funeral Service</i>								

EGM 930

1



031012

SHAFFERS FUNERAL HOME

1- FOR STATE REGISTRAR
230 E. MAIN STREET
ROMNEY, WV 26757STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00051

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			CLARA	GENEVA	LEE	JANUARY 16, 1986				3:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR August 9, 1925		60		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY			
West Virginia		U.S.A.						MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
Cumberland								99999 26763			
13a. STATE		13b. COUNTY		13c. CITY, OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rural			
WV		Hampshire		Springfield							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	Laura	MIDDLE	Bryant	LAST
		Ollie	R.	Landis							Bean
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		17. ADDRESS					
No		236-36-1985		Leldon I. Lee,		Springfield, WV 26763					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sangrenous bowel</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe narrowing of mesenteric artery</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Recent influenza</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Gas bubbles in bowel</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute abdomen</i>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
1-16-86											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-16-86</i> to <i>1-16-86</i> , that (I) (we) last saw the deceased alive on <i>1-16-86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		<i>1-20-86.</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ADDRESS		909-B SETON DRIVE CUMBERLAND, MD 21502					
JOHN MEHANNA											
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Forest Glen		23d. LOCATION CITY OR TOWN Greenspring		COUNTY	STATE		
Burial		1/19/86							WV		
24. FUNERAL DIRECTOR NAME <i>Keith S. Shaffer</i> ADDRESS <i>Shaffer Funeral Home, Romney, WV</i>											
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
JAN 27 1986		<i>J. Shaffer - R. Shaffer</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove all loose papers, staple 1 and 2 together and attach to the burial or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MAJOR ANTI If item 21 is marked or item 18 shows any injury, or other traumatic medical condition, attach an additional page.

999999
BP
DHMH - 16-80M 7/84
(VRA 15, 4)

101015
CLAYTON HOME
30 E. MAIN STREET
ROCKY MOUNT, NC

CLAY CLAYTON HOME

WILSON COUNTY

SEARCHED INDEXED

010-08-1002

SEARCHED INDEXED
SERIALIZED FILED

JULY 10 1968

024196

1 - FOR
STATE
REGISTRAR

0005

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
HELEN EVA LEGROS						January 13, 1986			P 12:15 M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Female		White		MONTH 10	DAY 20	YEAR 1922	63 YRS			IF UNDER 7-1/2 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Massachusetts		USA					Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Own home	
Cumberland		Memorial Hospital		Homemaker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Pa.		13b. COUNTY Bedford		13c. CITY OR TOWN Bedford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RD #5 Box 632 99999			
14. FATHER'S NAME FIRST Alfred		MIDDLE Ieger		LAST		15. MOTHER'S MAIDEN NAME FIRST Della		MIDDLE		LAST Mallet	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 014-18-9951		17. INFORMANT Robert C. LeGros		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS RD #5		Bedford, Pa. 15522	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 L E</i> 1012 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Thrombocytopenia</i>											
19a. DATE OF OPERATION <i>Dec 1985</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>for diagnosis</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1974</i> , 19_____, to <i>i-13</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>1-13</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John T. Whitmore MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-13-86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John T. Whitmore		22e. ADDRESS 1068 National Hwy. La Vale, Md. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-17-86		23c. NAME OF CEMETERY OR CREMATORIAL St Josephs Catholic		23d. LOCATION CITY OR TOWN Fitchburg		COUNTY Worcester		STATE Mass.	
24. FUNERAL DIRECTOR NAME Timothy A. Berkebile		ADDRESS 214 S. Juliana St.		25a. DATE REC'D. BY REGISTRAR JAN 20 1986		25b. REGISTRAR'S SIGNATURE <i>Julie Dawson-Pondale</i>					

EXOGENAL

017087

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-2 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. FORMS PA-1 AND 25 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PINESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00059
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
Albert				Lynch		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	6	1986	1201P
SEX	RACE	3. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Male	Cau	SEPT 30 1914	71 yrs.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	6	1986	1201P
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
PENNA.		USA						ALLEGANY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Memorial Hospital						RETIRED KELLY SPRINGFIELD TIRE				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN La Vale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14 Vocke DRIVE		21502		
14. FATHER'S NAME FIRST CHARLES		MIDDLE		LAST LYNCH		15. MOTHER'S MAIDEN NAME FIRST ELIZA		MIDDLE		LAST THOMPSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII		16c. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		17. INFORMANT MARTHA LYNCH 14 VOCKE DRIVE LAVALE MD.		ADDRESS				
				Cardio-pulmonary arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden				
				} (b) Cardio-vascular heart disease DUE TO, OR AS A CONSEQUENCE OF				years				
				(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Dpty								DATE SIGNED 1/6/86		
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER										
Paul Snow, M.D.		ADDRESS Memorial Hosp. Cumberland Md 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 9 1986		23c. NAME OF CEMETERY OR CREMATORIY ROCKY GAP VETERANS CEMET		23d. LOCATION CITY OR TOWN FLINTSTONE RFD ALLEGANY MD.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.		25a. DATE REC'D. BY REGISTRAR JAN 9 1986								25b. REGISTRAR'S SIGNATURE Julie Anderson-Pendell		

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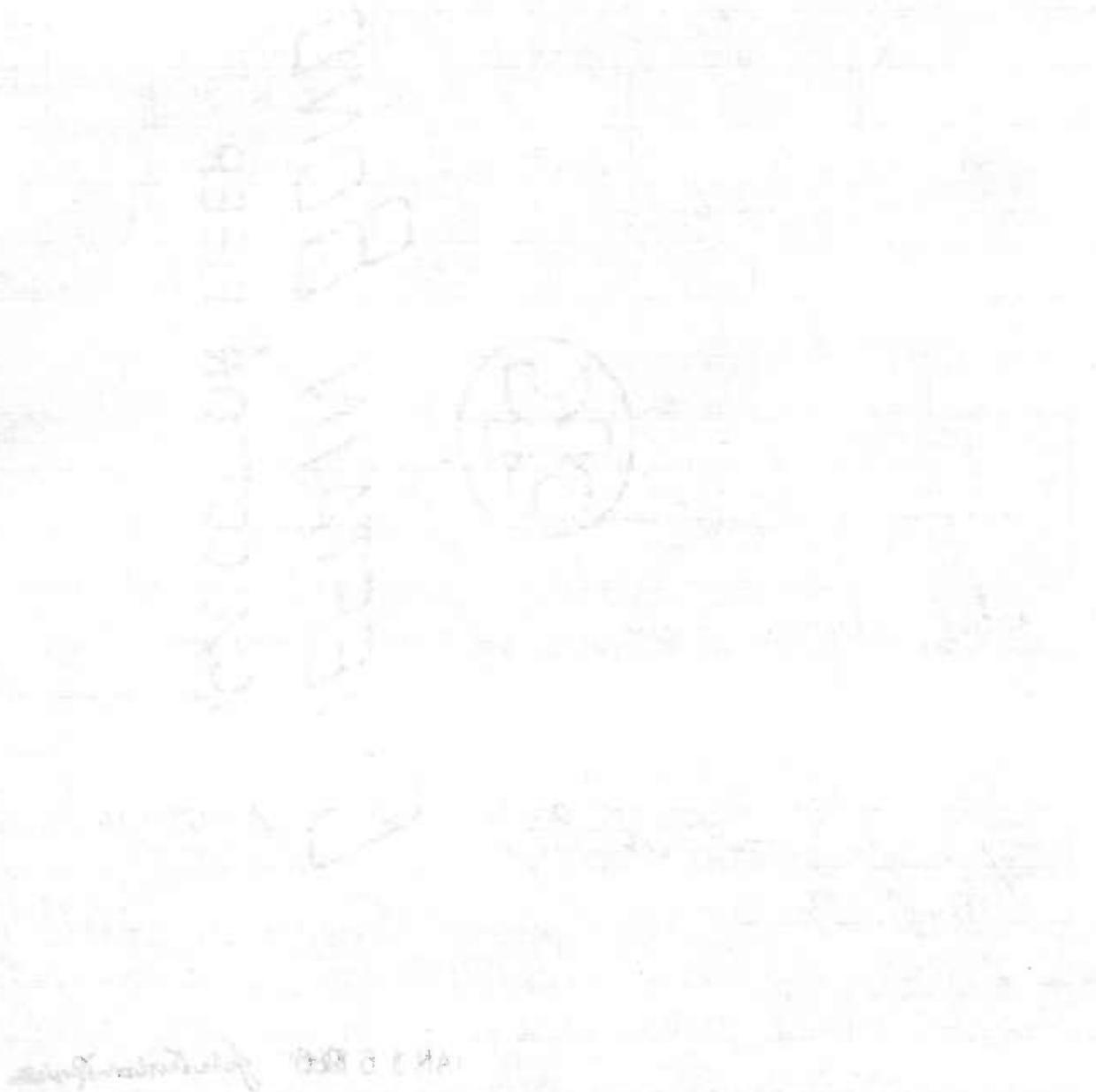
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician it should be detached for use as the burial-tranfer permit. Then please remove carbon copy and mail to the State Dept. of Health and Mental Hygiene prior to burial. Cremation with the State Dept. of Health and Mental Hygiene prior to burial, cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, attach a separate sheet of paper and describe the condition.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	0	0	0	6				
										REG. NO.									
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			MARY			JANE			MCCLAREN			JANUARY 12, 1986			12:31P.		M		
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
female			white			MONTH DAY YEAR			YRS.			MONTHS DAYS			HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD							
PA			USA						Allegany										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME, ADDRESS, FACILITY CODE, STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
CUMBERLAND			MEMORIAL HOSPITAL			housewife			own home										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
MD			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			128 Virginia Avenue/21502							
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Roy Schucker									Viola Dunlap										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 203-20-6970			17. INFORMANT ADDRESS Rev. Lloyd C. McClaren, Cumberland, MD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Shock</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertension</i>																			
{ DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Mitral Valvular Disease</i>																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1-4</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															<i>12-30-85 to 1-12-86</i>				
22b. SIGNATURE <i>Haner</i>															DEGREE				
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															22d. DATE SIGNED <i>1-13-86</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARRERA															MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 01-15-1986			23c. NAME OF CEMETERY OR CREMATORY Rosedale Funeral Chapel			23d. LOCATION CITY OR TOWN Martinsburg			COUNTY STATE Berkeley WV							
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502															24. DATE RECEIVED BY REGISTRAR JAN 16 1986				
															24. REGISTRAR'S SIGNATURE <i>J. F. Scarpelli</i>				

CLASS



035055

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Richard Leo McClelland			RICHARD	LEO	MCCLELLAND	January 29, 1986				2:15 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Jan. 24, 1921		65		YRS.	MONTHS	DAYS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U.S.A.				Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		Memorial Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Allegany		Cumberland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 8 Box 291		21502	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
John		Claire		McClellan		Mary		Ann		Fink	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		ADDRESS			
Yes		WWII		220-10-4571		Mary Frances McClelland		same as 13a-e			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Adult respiratory Distress Syndrome				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Viral pneumonia									
{		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Post pneumonia, pt. in adeno ca. of lung											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
22d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____							
22e. I certify that (I) (this hospital) attended the deceased from <u>1-29-86</u> to <u>1-29-86</u> , that (I) (we) last saw the deceased alive on <u>1-29-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22f. SIGNATURE <u>R. J. Barrera</u>		22g. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22h. DATE SIGNED <u>1-29-86</u>					
22i. PHYSICIAN'S NAME (TYPE OR PRINT)		22j. ADDRESS									
Dr. R. J. Barrera, M.D.		Memorial Hospital Med. Cumberland, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____					
Burial		1/31/86		Sunset Memorial park		Cumberland Alleg. MD					
24. FUNERAL DIRECTOR NAME		Leasure-Stein Funeral Home, Inc.		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Leasure-Stein</u>					
				JAN 31 1986							
BP											

66000

REBELLION COMMITTEE



300 TO MAIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the death notice permit. Then please remove carbon paper. Pages 1 and 2 will be used with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT AND: Item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified.

035023

BOALS FUNERAL HOME 111 CHURCH STREET WESTERNPORT, MD 21562			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			8 6 0 0 0 6 2				
						CERTIFICATE OF DEATH				REG. NO.
DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	HOUR		
<i>Donald</i>	<i>Aubrey</i>	<i>McIntyre</i>		JANUARY 26, 1986				9:50A M		
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4 30 1914</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>71</i>	IF UNDER 1 YEAR <i>YRS.</i>	IF UNDER 21 HRS <i>MONTHS DAYS</i>	IF UNDER 21 HRS <i>HOURS MIN.</i>				
7. BIRTHPLACE <i>Maryland</i>	7b CITIZEN OF WHAT COUNTRY? <i>usa</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>ALLEGANY COUNTY MD</i>							
10. CITY OR TOWN OF DEATH <i>Cumberland</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SACRED HEART HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Insurance Agent Insurance</i>						
13a. STATE <i>West Virginia</i>	13b. COUNTY <i>Mineral</i>	13c. CITY OR TOWN <i>Keyser</i>	13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET ADDRESS / ZIP CODE <i>525 Carskaden Lane 26726</i>						
FATHER'S NAME FIRST <i>Aubrey</i>	MIDDLE <i>C.</i>	LAST <i>McIntyre</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Edna</i>	MIDDLE <i>G.</i>	LAST <i>Ack</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>	16b. SOCIAL SECURITY NO. <i>WWII 375-01-8823</i>	17. INFORMANT <i>Mrs. Dorothy McIntyre Keyser, W.Va. 26726</i>			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Vent. fibrillation</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cor. Art. Dis.</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Myocardial Infarction, Diab. Mell. C. H.P.</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <i>NO</i>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <i>NO</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/23 1986</i> to <i>1/26 1986</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>C. J. Vincent</i>	22c. DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Clarence Vincent, MD</i>	22e. ADDRESS <i>909-B SETON DRIVE, CUMBERLAND, MD 21502</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>1/29/86</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Philos Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Westernport Allegany Md.</i>	STATE						
24. FUNERAL DIRECTOR NAME <i>Wayne Boath</i>	ADDRESS <i>Boals Funeral Service Westernport, Md. 21562</i>	25a. DATE REC'D. BY REGISTRAR <i>JAN 31 1986</i>	25b. REGISTRAR'S SIGNATURE <i>Anna Landon Rendall</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completed) filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon copy (page 4) and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Yes" (see page 18), answer 18 above any injury, or other traumatic event.

017036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 00063

1. STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Floyd B. McIntyre</i>						1	8	86	8:00 A.M.		
3. SEX			RACE	S. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	# UNDER 24 HRS			
<i>Male</i>			<i>Caucasian</i>	<i>Nov. 18, 1910</i>		<i>75</i>					
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			7d MONTHLY INCOME				7e BALTIMORE CITY OR COUNTY OF DEATH	
<i>MD</i>			<i>USA</i>			<i>\$100.00</i>				<i>Allegany</i>	
8. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (IF OF 16 YEARS OF AGE OR OLDER, GIVE FORMER OCCUPATION)				12b. KIND OF BUSINESS OR INDUSTRY	
<i>Frostburg</i>			<i>Frostburg Village Nursing Home</i>			<i>Retired Farmer</i>				<i>MD</i>	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
<i>MD</i>			<i>Garrett</i>	<i>Barton</i>	<i>YES</i>	<i>RD 1, Box 185</i>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS					
<i>John W. McIntyre</i>			<i>Ursula Blanche Harvey</i>			<i>Barton, MD</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
<i>No</i>			<i>214-12-3498</i>			<i>Mary A. McIntyre, RD 1, Box 185</i>				<i>21521</i>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b) and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>Cardiac Arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral infarction</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypothyroidism</i>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b) <i>CHD</i>											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							<i>NO</i>	<i>YES</i>	<i>NO</i>	<i>NO</i>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, IF ANY, IN PART 1b OR PART 2)								
21d. INJURY OCCURRED WHILE WORKING NOT WHILE WORKING		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE		
22a. I certify that (i) this hospital attended the deceased from <i>Dec 4, 1986</i> to <i>Jan 8, 1986</i> , that (ii) we last saw the deceased alive on <i>Jan 8, 1986</i> and that (iii) our opinion death occurred on the date and hour and from the causes stated above, (i) and (ii) did not view the body after death.											
22b. SIGNATURE		22c. DEGREE				22d. DATE SIGNED					
<i>Chang-hyun Oh, M.D.</i>						<i>Jan 10, 1986</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS				22g. ADDRESS					
<i>Chang-hyun Oh, M.D.</i>		<i>Frostburg, Md. 21532</i>									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				
<i>Burial</i>		<i>1-11-86</i>	<i>Frostburg Mem. Park</i>				<i>CITY OR TOWN</i>				
23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE									
						<i>JAN 14 1986</i>					
24. FUNERAL DIRECTOR NAME		ADDRESS				25e. DATE REC'D. BY REGISTRAR					
<i>Eichhorn Funeral Home, Lonaconing, MD</i>		<i>21532</i>									

2007.10

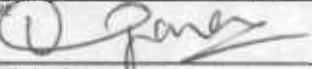


031058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND SCARPELLI FUNERAL HOME DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										00064			
1. FOR STATE REGISTRAR 108 VA. AVE. CUMBERLAND, MD										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
DAVID R. MCMILLAN SR.						JANUARY 19, 1986			9:20 A M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05-30-1930			6. AGE (IN YEARS LAST BIRTHDAY) 55 yrs		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE COUNTRY MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY		MD.				
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY El. Local 307					
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 1 Box 159/21555				
14. FATHER'S NAME FIRST MIDDLE LAST David S. McMillan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie I. Myers											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 213246560			17. INFORMANT Mrs. Theresa L. McMillan, Oldtown, MD-wife								
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardio - Respiratory Arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DOUE TO, OR AS A CONSEQUENCE OF (b) Peter staric Ca. Glor.											
(c)		DOUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE 			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502			DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22f. DATE SIGNED 1/19/86								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 01-22-1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery			23d. LOCATION CITY OR TOWN Cumberland Allegany MD		23e. COUNTY STATE				
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR JAN 27 1986			25b. REGISTRAR'S SIGNATURE 								

SCARFETT, PHILIP JAMES HENRY
100 AV. AVE. CHINCHILLA, CO

1967
JANUARY 15 1968

MR. MCKEEAN, JR.

DAVIS

ALLEGHENY COUNTY

ATTACHMENT SHEET

B7
SEARCHED

GENERAL MEDICAL FILE, CHINCHILLA

J.M. HANAS RABO

014011

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 00065
1 - STATE REGISTRAR	FIRST EDNA	MIDDLE LORAIN	LAST METZGER	2a. DATE OF DEATH January 5, 1986
1.1. DECEASED NAME (TYPE OR PRINT)	1.2. RACE white	1.3. DATE OF BIRTH MONTH 09-04-1912 YEAR	1.4. AGE IN YEARS (AT BIRTHDAY) 73	1.5. HOUR 10:05 A.
3. SEX female	4. RACE white	5. CITIZEN OF WHAT COUNTRY? USA	6. AGE IN YEARS (AT BIRTHDAY) 73	1.6. IF UNDER 1 YEAR MONTHS YRS
7a. BIRTHPLACE COUNTRY PA	7b. CITY OR TOWN Memorial Hospital	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany	1.7. IF UNDER 24 HRS HOURS MIN.
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital	12a. USUAL OCCUPATION housewife	12b. KIND OF BUSINESS OR INDUSTRY OWN home	
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Harry	MIDDLE Morehead	LAST	15. MOTHER'S MAIDEN NAME FIRST Amy Ickes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 214-62-4173	17. INFORMANT Mr. John V. Metzger, Cumberland, MD - husband	ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Artery Disease</u>				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>N/A</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Poor Left Ventricular Function 2nd to Cardiac Vas. Disease</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A	21b. TIME OF INJURY HOUR A.M. MONTH P.M. /A YEAR 19	21c. HOW INJURY OCCURRED N/A	ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET N/A	CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-4-86</u> to <u>1-5-86</u> , 19_____, that (I) (we) last saw the deceased alive on <u>1-5-86</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if) (we) (did) (did not) view the body after death.				
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Howard Diener		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 1/6/86		22d. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01-07-1986	23c. NAME OF CEMETERY OR CREMATORIAL Rocky Gap V/A Cem.	23d. LOCATION CITY OR TOWN Flintstone Allegany MD COUNTY STATE	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502	ADDRESS	25a. DATE REC'D. BY REGISTRAR JAN 8 1986	25b. REGISTRAR'S SIGNATURE John Davidson Jr.	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			ROBERT	LEE	MEYERS	January 18, 1986			12:00noon M		
3 SEX		4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
male		white	MONTH DAY YEAR			78	MONTHS	YEARS	MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
MD		USA				Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		Memorial Hosp. & Medical Center					retired			railroad	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
MD		Allegany	Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		104 Blackiston Avenue/21502				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		George	Henry	Meyers			Effie	Rebecca	Burkhart		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		ADDRESS				
no		705-07-9683			Mrs. Bertha M. Meyers, Cumberland, MD - wife						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>left sided CVA</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Pneumonia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART II)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1/18/1986 to 1/18/1986, that (we) last and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Skewett Hall</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			
22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502											
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Raver											
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE 01-21-1986		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		23d. LOCATION CITY OR TOWN Cumberland		COUNTY Allegany	MD		
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR JAN 27 1986			25b. REGISTRAR'S SIGNATURE <u>John Anderson</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial transit permit. Then place it with the State Dept. of Health and Mental Hygiene prior to burial. IMPORTANT: If item 21 is marked or item 18 shows any injury, or otherwise affects the medical history, attach a separate sheet of paper giving the medical history.

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OCTOBER 1940
1940

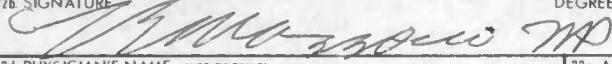


036047

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be continued on back.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 3 and 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

GEORGE UPCHURCH FUNERAL HOME FOR GREEN STREET 1 - STATE REGISTRAR CUMBERLAND, MD 21502			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			00067								
						REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
ALTHENE LYNN MORGAN						JANUARY 30, 1986						6:15 A.M.		
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH AK ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Svc-Allegany Bd. of Ed.			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 709 Ridge Terrace / 21502						
14. FATHER'S NAME FIRST John			MIDDLE P.	LAST Smarr	15. MOTHER'S MAIDEN NAME FIRST Alma			MIDDLE -	LAST Teauton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-22-6573			17. INFORMANT John Morgan			ADDRESS 701 McKinley Ave. Cumberland, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			{ (b) Chronic Obstructive Lung Disease						years					
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:														
Pulmonary Emboli Congestive Heart Failure														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE 			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1-30-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Victor Mazzocco, M.D.			22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-1-86			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Lawn Meml. Gdns.			23d. LOCATION CITY OR TOWN LaVale-Allegany Co.-Maryland			STATE Maryland		
24. FUNERAL DIRECTOR NAME George Upchurch Funeral home, P.A.			25a. DATE REC'D. BY REGISTRAR FEB 03 1986			25b. REGISTRAR'S SIGNATURE 								
ADDRESS 202 Greene Street-Cumberland, Maryland 21502														

EXPOSED BY CHRONIC EXPOSURE
GREEN STATE
OCTOBER 10, 1963

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W.H.E.

THE VITERNY COMPANY

SURGEON HERBERT HEDRILL



CHARTERED ACCOUNTANT, BIRMINGHAM, AND CHIEF

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER CARD. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF NATURE RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00068	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR 8:30 AM
FREDA L. MORGAN						1/6	1986						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONONCED DEAD				MONTH	DAY	YEAR	2d. HOUR 8:45 PM
FEMALE	WHITE	7/22/07	78 yrs			1/6	1986						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED X		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH				
PENNSYLVANIA		U.S.A.							ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
NATIONAL			RT. 1, FROSTBURG					CAFETERIA				COLLEGE	
13a. STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN NATIONAL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. 1 FROSTBURG				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME EDITH				ADDRESS				
RUSSELL				LEADER	RUSSELL MORGAN, BARTON, MD				BLACK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
NO			N.A.			RUSSELL MORGAN, BARTON, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST												SUDDEN	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													
(b) HYPERTENSIVE CARDIOVASCULAR HEART DISEASE												YEARS	
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)		M.D.		DEPUTY		MEDICAL EXAMINER		DATE SIGNED 1/6/86	
EXAMINER'S NAME (TYPE OR PRINT)		PAUL SNOW, M.D.		ADDRESS		MEMORIAL HOSPITAL, CUMBERLAND, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1/9/86			23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PARK			23d. LOCATION CITY OR TOWN			COUNTY STATE	
BURIAL			1/9/86			FROSTBURG			ALLEGANY			MD	
24. FUNERAL DIRECTOR HAROLD M. SNOW			ADDRESS 60 W. MAIN ST.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
SOWERS FUNERAL HOME						JAN 13 1986							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician be executed within 24 hours after death. Page 4 may be

rejoined by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the physician it should be detached for use as the burial+transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If Item 21 is marked "lost" or "injury", or other unusual event, the medical examiner should be notified.

IMPORTANT: If Item 21 is marked "lost" or "injury", or other unusual event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86	00069	
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
JOHN FRANCIS MULLAN						JANUARY 31, 1986					0433	A		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
male		white		MONTH DAY YEAR			68			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9			BALTIMORE CITY OR COUNTY OF DEATH				
MD		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Allegany			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL						retired			textile		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD			Allegany		Flintstone					Route 1 Box 376/21530				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST John Leo Mullan			MIDDLE LAST						FIRST Mary A. Eirich			MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
yes			WW II			217-10-6892			Mrs. Mary J. Mullan, Flintstone, MD - wife					
18. CAUSE OF DEATH (Enter only one cause per line for immediate and underlying causes. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocard MI, Cudugonae Street</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CAD</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b <i>COOT</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Jan 30 86 Jan 2</i>			21f. LOCATION STREET <i>86</i>			CITY/TOWN <i>Jan. 31, 1986</i>			COUNTY	STATE	
22a. I certify that (I) (this hospital) <i>Jan 30 86</i> to <i>Jan. 31, 1986</i> , that (I) (we) lost saw the deceased alive on <i>Jan 30 86</i> (date) (time) (place) (name) above (I) (we) (did) (died) (died) the body after death.			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <i>Mullanis</i>			DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2-3-86</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS MEDICAL BUILDING MEMORIAL HOSPITAL, CUMBERLAND, MD 21502											
DR. TERRY WILLIAMS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN Cumberland			COUNTY Allegany	STATE MD	
Burial			02-03-1986			SS Peter Paul Cemetery			FEB 05 1986			25a. DATE REC'D. BY REGISTRAR <i>Feb 05 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Judy Davidson Pendell</i>
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502			ADDRESS											



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER STATEMENT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR Cremation.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH					REG. NO. 00070
1. DECEASED NAME (TYPE OR PRINT)		FIRST LOUISE	MIDDLE W.	LAST MURPHY	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 1-6-86 19 M
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 07-15-1913	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2b. HOUR 1-6-86 19 M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		2c. DATE PRONOUNCED DEAD 1-6-86 19 2:50P	
8. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County
13a. STATE MD		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST Dennis Ambrose Murphy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Dreyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-10-7901		17. INFORMANT ADDRESS Anna C. Clipp, Baltimore, MD - sister	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries to brain with old infarcts of 888 DUE TO, OR AS A CONSEQUENCE OF cerebellum and brain Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR P.M. MONTH DAY YEAR 5:00 P.M. 1/5 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Margarita Korell		TITLE (SPECIFY) M.D. Assistant		DATE 1-7-86 SIGNED	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-10-1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Lukes Cemetery	
24. FUNERAL DIRECTOR NAME James F. Scarpelli		ADDRESS Cumberland, MD 21502		25. DATE RECEIVED BY FUNERAL DIRECTOR JAN 13 1986 REGISTRAR'S SIGNATURE J. Scarpelli	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/Mental Hygiene permit. Then please remove carbon paper. Pages 1 and 2 should be left within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If item 21 is marked as INJURY, item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

HAFER FUNERAL HOME
LAVAL, MDSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8600071

020063

1 - FOR
STATE
REGISTRAR

21502

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ALBINO J			NICOLATO, SR			JANUARY 9, 1986			8:25 AM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		White	Month Day Year Aug. 31, 1891			94 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.			
Italy		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		SACRED HEART HOSPITAL			Groundsman			Hospital			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 3, Box 303 / 21557			
Maryland		Allegany		Rawlings							
14. FATHER'S NAME FIRST		MIDDLE	LAST			15. MOTHER'S MAIDEN NAME		16. ADDRESS			
Geralamo			Nicolato			Carlina		Fongaro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____			
No		218-24-8365			Albino J. Nicolato, Jr. - same as above			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Head trauma Congestive Heart Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) saw the deceased alive on Jan 9 1986 and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JAN 5 1986 to JAN 9 1986 that (I) (we) lost saw the deceased alive on Jan 9 1986 and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death											
22b. SIGNATURE Paul J. Livengood MD		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1-12-86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Livengood MD		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/86		23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Cem.			23d. LOCATION Frostburg, Alleg., MD			24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. LaVale, MD 21502	
										25a. DATE REC'D. BY REGISTRAR JAN 16 1986	
										25b. REGISTRAR'S SIGNATURE <i>sl</i>	

028165

Sowers Funeral Home

FOR STATE 60 West Main Street
REGISTRAR Frostburg, MD 21532STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

P 6 0 0 0 7 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
			Harry	Clarence	Ort	January 18, 1986				11:35PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		WHITE		MONTH	DAY	YEAR	78	YRS	MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.				Allegany County, MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
CUMBERLAND		Sacred Heart Hospital		MASTER BAKER		BAKERY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13e. STREET ADDRESS / ZIP CODE 311 EAST MAIN STREET 21532						
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	21532		
CLARENCE				ORT	MARGARET				Mac FARLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO N.A.			17. INFORMANT ANNA STORM BURG, MD 21532			ADDRESS WASHINGTON ST., FROSTBURG, MD 21532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
						DUE TO, OR AS A CONSEQUENCE OF (c) Lung Abscess						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 chronic obstructive lung disease, etc.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 21)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Clarence Vincent, M.D.</i>		DEGREE				22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clarence Vincent, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22e. ADDRESS 909-B Seton Drive, Cumberland, MD 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1/20/86		23c. NAME OF CEMETERY OR CREMATORIUM SMITHBURG CREMATORIUM		23d. LOCATION CITY OR TOWN SMITHBURG		WASHINGTON CO. MD.				
24. FUNERAL DIRECTOR NAME <i>Charles M. Sowers</i>		ADDITIONAL NAME 60 W. MAIN ST. FROSTBURG		25a. DATE REC'D. BY REGISTRAR JAN 23 1986		25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>						

be executed within 24 hours of death. Page 4 may be

relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remember to file with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SOURCE OF INFORMATION: 00000000000000000000000000000000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be

renamed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered for use as the burial permit. Then please have it filed with the State Dept. of Health and Mental Hygiene prior to burial, removal,

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 00073

020058

1. DECEASED NAME (TYPE OR PRINT)			FIRST HAZEL	MIDDLE LORRAINE	LAST POLING	2a DATE OF DEATH JANUARY 7, 1986	MONTH JAN	DAY 7	YEAR 1986	2b HOUR 11:30PM				
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR MARCH 8 1909			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS					
									IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN.				
7a BIRTHPLACE COUNTRY VA.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY MD.					
10 CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRES			12b KIND OF BUSINESS OR INDUSTRY -----					
13a STATE MD.			13b COUNTY ALLEGANY			13c CITY OR TOWN CUMBERLAND			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST LEMUEL			MIDDLE L	LAST COMBS				15. MOTHER'S MAIDEN NAME FIRST ALICE			16. STREET ADDRESS / ZIP CODE PACA STREET QUEEN CITY TOWERS 21502			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 214-12-3315			17. INFORMANT mrs WILLIS ROBERTSON RFD#5 BOX 320 CUMBERLAND			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days					
18 CAUSE OF DEATH (Enter only one cause per line for item 18, Part 1, and item 19.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brown meningitis</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Septicemia</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19	21f. LOCATION STREET 19			CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from showing the deceased alive on (date) 19 to (date) 19, that (I) (we) last saw the deceased alive on (date) 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, check here.)														
22b. SIGNATURE <i>Guy Ficus</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/8/86					
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GUY FICUS			23c. NAME OF CEMETERY OR CREMATORIUM REST LAWN CEMETERY			23d. LOCATION CITY OR TOWN LAVAL ALLEGANY MARYLAND			22e. MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502					
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JAN 10 1986			25a. DATE REC'D. BY REGISTRAR JAN 13 1986			25b. REGISTRAR'S SIGNATURE <i>Julie Davison-Parkall</i>					
24. FUNERAL DIRECTOR NAME SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MARYLAND			ADDRESS											

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove this from the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury or other trauma event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 00074				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
EDNA			PEARL	RALSTON		January 19, 1986						11:15 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		MONTH DAY YEAR 05-16-1917		68			MONTHS	YEARS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MD		USA				Allegany			MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland		Memorial Hospital & Med. Center								housewife		OWN home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
MD		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12 West First Street/21502					
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME			FIRST		LAST			
		Riley		Robertson					(nmn)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS							
no		212-54-8156		Ronney & Glendon Ralston - sons										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>asystole</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) <i>ASCVD & CAD & CHF</i>														
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>100m</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1986, to 1/17, 1986, that (I) (we) last saw the deceased alive on 1/17/86 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22b. SIGNATURE <i>J. T. Elder</i>		
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22d. DATE SIGNED 1/29/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502												
Dr. T. Elder														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE		
Burial		01-21-1986		Davis Memorial Cem.		Cumberland			Allegany			MD		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE												
James F. Scarpelli, Cumberland, MD 21502		JAN 27 1986 <i>John J. Scarpelli</i>												
DHMH - 16 60M 7/B4 (VRA 15, 4)														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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KIGHT FUNERAL HOME 309 DECATUR STREET Cumberland, MD 21502			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO. <i>Item Number 80075 Call 2-38654</i>		
1. DECEDENT'S NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Lenora A. Ready				January 24, 1986				3:25A M
3. SEX Female	4. RACE USA White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1897	6. AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS DAYS hrs min.	IF UNDER 24 HRS HOURS 3:25A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County, MD.					
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator		12b. KIND OF BUSINESS OR INDUSTRY Tire Co.		
13a. STATE MD	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 604 A Frederick St. 21502				
14. FATHER'S NAME FIRST Michael	MIDDLE	LAST Ready	15. MOTHER'S MAIDEN NAME FIRST Anna	MIDDLE	LAST Lynch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-07-0400	17. INFORMANT Edward Mattingly, Sr.	ADDRESS Cumberland, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizures			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10:00A.M.					
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Stroke								
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNINTENTIONAL <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10:00 AM 19 19	21c. HOW INJURY OCCURRED N/A	(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET N/A	CITY OR TOWN	COUNTY	STATE			
22a. I certify that the (this) hospital attended the deceased from JAN 24 1986 to JAN 24 1986 , that he (we) last saw the deceased alive on JAN 24 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE Bruce Behounek, M.D.			DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/24/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Behounek, M.D.			22e. ADDRESS BMG, 912 Seton Drive, Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 27, 1986	23c. NAME OF CEMETERY OR CREMATORIAL St. Particks Cemetery	23d. LOCATION CITY OR TOWN Mt. Savage Allegany MD					
24. FUNERAL DIRECTOR NAME William G. Kight	ADDRESS Cumberland, MD	25a. DATE REC'D. BY REGISTRAR JAN 27 1986	25b. REGISTRAR'S SIGNATURE <i>W.G. Kight</i>					

Jan. 23, 1882. Extrafictitious Com. vs. Mr. Basade Vifford and
others.

William G. Kilduff Consulting Ltd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the funeral director's permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as being 18 or more years old, show any injury, or other traumatic event, the medical certifying physician must sign this section.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 86 00076

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR		
Robert W. Resser						01	10	86	8:30	P		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		White		MONTH	DAY	YEAR	83	YRS.		IF UNDER 21 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
PA		USA								Allegany MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		Lions Manor Nursing Home					Machine Operator					
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
MD		Allegany		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			235 Paca Street 21502					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
		George	M.	Resser				Sally		Jacobs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
Yes		Unknown		188-03-7287			Anna M. Resser, 235 Paca St., Cumberland MD					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe C.H.F.												
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.												
{ DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic renal failure.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1985, to 1-10, 1986, that (I) (we) lost sow the deceased alive on 1-10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE V.A. Ranjithan		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 1-13-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.		22e. ADDRESS LMNH, Seton Drive, Cumberland, MD21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/1986		23c. NAME OF CEMETERY OR CREMATORY Susquehanna Memorial Gardens			23d. LOCATION CITY OR TOWN York Twp., York PA					
24. FUNERAL DIRECTOR NAME Burg Funeral Home, Inc., 134 W. Broadway, Red Lion, PA		ADDRESS JAN 20 1986					25b. REGISTRAR'S SIGNATURE John K. Kriden, R.D.					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00071

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Mary</i>	MIDDLE <i>Ethel</i>	LAST <i>Rose</i>	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH <input checked="" type="checkbox"/> 1	DAY <input type="checkbox"/> 7	YEAR <input type="checkbox"/> 1986	2b. HOUR <input checked="" type="checkbox"/> 2:00PM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH <input type="checkbox"/> 1	DAY <input type="checkbox"/> 7	YEAR <input type="checkbox"/> 1986	2d. HOUR <input checked="" type="checkbox"/> 2:00PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Allegany</i>					
10. CITY OR TOWN OF DEATH <i>Cumberland</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sacred Heart Hospital (DOA)</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ret. teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bd of Education</i>			
13a. STATE <i>MD</i>	13b. COUNTY <i>Allegany</i>	13c. CITY OR TOWN <i>Cumberland</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>301 Baltimore Street/21502</i>						
14. FATHER'S NAME FIRST <i>Ross</i>		MIDDLE <i>Rose</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>		MIDDLE <i>Heming</i>	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>213-18-2496</i>		17. INFORMANT <i>Sister Rosemary VanAusdale</i>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause of death. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Francisco Reyes</i>		TITLE (SPECIFY) <i>M.D.</i>		Deputy		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) <i>Francisco Reyes</i>		ADDRESS <i>900 Seton Dr. Cumberland Md.</i>						DATE SIGNED <i>1-7-87</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>01-09-1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>SS Peter Paul Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Cumberland</i>		23e. COUNTY <i>Allegany</i>		STATE <i>MD</i>	
24. FUNERAL DIRECTOR NAME <i>James F. Scarpelli</i>		ADDRESS <i>Cumberland, MD 21502</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 13 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Scarpelli</i>					

66030

3

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00078

020233

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER OR CLERK OF THE COURT FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE USED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 200 W. PINESTON STREET,

MILITARY INFORMATION INTELLIGENCE

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST				REG. NO.					
Elmer Joseph Rosenberger												
3. SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	20. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	26. HOUR		
M	W	Dec 1, 1908 77 yrs.				<input type="checkbox"/>	1	2	1986	12:36		
10. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR
MARYLAND		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		1. BALTIMORE CITY OR COUNTY OF DEATH			12:36M		
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION			12b. KIND OF BUSINESS (OR INDUSTRY)		
Cumberland		D.O.A. MEMORIAL HOSPITAL					CARPENTER			BUILDING		
13. AL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN												
MARYLAND		6 Garrett		FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RT. 2, Box 426, 21532			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
CLARENCE Rosenberger			Florence Warner									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> UNKNOWN			16b. SOCIAL SECURITY NO.									
Yes W.W. 2			216-18-1761									
17. INFORMANT ADDRESS Edna Rosemberger, 13E												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease, Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) Probably stroke. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Francisco Reyes			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 1-2-86			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 900 Seton Dr. Cumberland, Md. 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE JAN 5, 1986		23c. NAME OF CEMETERY OR CREMATORIAL GREENVILLE CEMETERY, YOCOHONTAS PA.		23d. LOCATION CITY/TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Durst Funeral Home			ADDRESS Frostburg, Md.			25a. DATE REC'D. BY REGISTRAR JAN 13 1986			25b. REGISTRAR'S SIGNATURE John Durst			

26AUGO



027045

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

B6 00079

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
				Elizabeth	H.	Rosenmerkel	01	16	1986	2:15	A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		caus		04 01 1900		85		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Allegany		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Cumberland		Lions Manor Nursing Home		Ret. Nurse		County Goven					
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 708 Shriver Ave. 21502					
14. FATHER'S NAME HUSBAND		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Unknown		MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		17. INFORMANT 218-38-2318 Diana Roberts		ADDRESS Frederick, MD					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Cerebrovascular accident.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation.									
{		DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic brain syndrome											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-9, 1979, to 1-16, 1986, that (I) (we) last saw the deceased alive on 1-13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. DATE SIGNED 01-16-86					
22b. SIGNATURE V.A. Ranjithan						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vimala Ranjithan						22e. ADDRESS Lions Manor Nursing Home, Cumberland, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Jan. 18, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION CITY OR TOWN Cumberland		23e. DATE REC'D. BY REGISTRAR JAN 23 1986			
24. FUNERAL DIRECTOR NAME William G. Kight		ADDRESS Cumberland, MD						25b. REGISTRAR'S SIGNATURE John Pendell			

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
reduced by the Hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial permit. Then please return certificate to the State Director of Health and Mental Hygiene prior to burial, cremation, or removal, with the State Death Certificate.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other treatments were the medical examiner will

053012
Baptist Jan 18, 1980 Chose Hill Cemetery Camping At Jesus MD

William G. Ridge Camping MD

HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from use as the burial-transit permit. Then please remove carbon/papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical director should be notified.

MARKWOOD FUNERAL HOME
STATE OF MARYLAND
11 MINERAL STREET
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
KEYSER, WVA 26726

00080

027044

1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH															
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			REG. NO.						
NORRIS			COLLINS			SCHADE			JANUARY 20, 1986				1:15 P.M.					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH March			DAY 9			YEAR 1908			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.									
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Electrician			12b. KIND OF BUSINESS OR INDUSTRY Westvaco									
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE W.Va.			13b. COUNTY Mineral			13c. CITY OR TOWN Keyser			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 416 South Main St. 99999						
14. FATHER'S NAME FIRST Tarson			MIDDLE H.			LAST Schade			15. MOTHER'S MAIDEN NAME FIRST Rose			MIDDLE Bell			LAST Grandstaff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No			17. INFORMANT Mr. Hollis L. Schade			ADDRESS LaVale, Md. 21502									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DO TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i> DO TO, OR AS A CONSEQUENCE OF (c) <i>Cor. Art. Dis.</i>																		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>A.S.C.Y.D</i>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/20</i> 19 <i>86</i> , to <i>1/20</i> 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>1/20</i> 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>C. J. Vincent</i>			22c. DEGREE MD.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CLARENCE VINCENT, MD			22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 23, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Potomac Mem. Gardens			23d. LOCATION CITY OR TOWN Keyser				COUNTY		STATE			
24. FUNERAL DIRECTOR <i>Gene E. McEse</i>			ADDRESS Box 912 Markwood-Cenzie Funeral Home, Keyser, W.Va.			25a. DATE REC'D. BY REGISTRAR JAN 23 1986			25b. REGISTRAR'S SIGNATURE <i>~n~ilson Rendall</i>									

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BP

TELEGRAMS 11
48502 AMT 1937

ST. LOUIS YACHT CLUB

1990 TRAIL 03202

例題11(3題目)

041006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 00081

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			ISAAC	JACOB	SHOBE	January 18, 1986			12:08 p.m.		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male		White	Aug. 11, 1916			69	YRS	MONTHS	DAYS	IF UNDER 23 HRS	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
W.Va.		U.S.A.						Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Memorial Hospital & Med Center			Farmer			Gen. Farming			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
13a. STATE W.Va.		13b. COUNTY Grant	13c. CITY OR TOWN Dorcus				General Delivery 99999				
14. FATHER'S NAME		FIRST Isaac	MIDDLE Shobe	LAST	15. MOTHER'S MAIDEN NAME			LAST Bergdoll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO OR UNKNOWN		16b. SOCIAL SECURITY NO. 215-18-1604			17. INFORMANT			ADDRESS			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Aspiration pneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Massive brain stroke								
{			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE			22d. DATE SIGNED						
Khefer Ashker		MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Khefer Ashker		22e. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 21, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Shobe Fam. Cemetery		23d. LOCATION CITY OR TOWN Dorcus, W.Va.		23e. COUNTY Grant County			
24. FUNERAL DIRECTOR NAME Arnold-Basagic Funeral Home Petersburg, W.Va.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Jan 21, 1986 John Davidson Pendell									

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the surgical folder and forwarded with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

MAJOR ANT: If item 21 is marked or item 22 is marked or both

BP
DHMH 16-0007-7/84
(Rev. 15-4)

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042010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from lines 1 and 2 should be read within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										B 6 0 0 0 8 2						
										REG. NO.						
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			JANUARY 29, 1986 11:59 M P										
ROBERT TAYLOR SHROUT SR																
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male			White			Apr 11 1913			72 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.							
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto Industry							
13a. STATE WV			13b. COUNTY Mineral			13c. CITY OR TOWN Keyser			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt 2 Box 107 26726				
14. FATHER'S NAME FIRST MIDDLE LAST Balford T Shroud			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilea Grapes			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes WW II			16b. SOCIAL SECURITY NO. 212-12-8383			17. INFORMANT Marie Lee Shroud			ADDRESS Rt 2 Box 107 Keyser, WV 26726	
18. CAUSE OF DEATH Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolism 15 days												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c)													
19. MEDICAL CERTIFICATION			20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from JAN 11 1986 to JAN 29 1986, that (I) (we) last saw the deceased alive on Jan 29 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death																
22b. SIGNATURE Paul Livengood MD			22c. DEGREE												22d. DATE SIGNED 1-30-86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Livengood, MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/1/86			23c. NAME OF CEMETERY OR CREMATORIAL Potomac Mem. Garrens			23d. LOCATION CITY OR TOWN Keyser			COUNTY Mineral			STATE WV	
24. FUNERAL DIRECTOR NAME A. Craig Rotruck			ADDRESS 85 S Main St Keyser, WV 26726			25a. DATE REC'D. BY REGISTRAR FEB 05 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

999999

WICHITA COUNTY

SUPERIOR INSURANCE

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22d is filled in, any injury, or other traumatic event, the medical examiner must be notified of same.

EICHORN FUNERAL HOME MAIN STREET LONACONING, MD. 21562

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 6 0 0 0 8 3

035144

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

NAIDENE WILCOX SIGLER

2a DATE OF DEATH MONTH DAY YEAR
JANUARY 27, 1986
2b HOUR
1:05PM3. SEX
Female4. RACE
White5. DATE OF BIRTH
Feb. 8, 19056. AGE (IN YEARS LAST BIRTHDAY)
80
IF UNDER 1 YEAR
MONTHS DAYS
YRS.7a BIRTHPLACE
(STATE OR FOREIGN)
W.Va.7b CITIZEN OF WHAT COUNTRY?
USA
8 MARRIED NEVER MARRIED
WIDOWED DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH
ALLEGANY COUNTY
MD10. CITY OR TOWN OF DEATH
Cumberland11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SACRED HEART HOSPITAL12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker
12b. KIND OF BUSINESS OR
INDUSTRY
Home13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. 13b. COUNTY
Allegany 13c. CITY OR TOWN
Lonaconing13d. INSIDE CITY LIMITS?
YES NO 13e. STREET ADDRESS ZIP CODE
Lonaconing, Md 2153914. FATHER'S NAME
FIRST MIDDLE LAST
A. Wilcox15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy B. Neeper16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
No (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.
None 214-04-624017. INFORMANT
Helen L. Buser, Rt 2 Box 1487, Ridgeley, W. Va. 26753ADDRESS
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH18. CAUSE OF DEATH (Enter only one cause per line for items 18a, b, c and d)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)*Cardiopulmonary Arrest*

1 Day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
b) *coronary artery dis*
DUE TO, OR AS A CONSEQUENCE OF
c) *Years*
DUE TO, OR AS A CONSEQUENCE OF

Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY?
YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d. INJURY OCCURRED
WHILE AT WORK NOT WHILE AT WORK
21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Paul Livengood DEGREE
ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN 22c. DATE SIGNED
1-28-8622d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL LIVENGOOD, M.D. 22e. ADDRESS
BMG, 912 SETON DRIVE, CUMBERLAND, MD. 2150223a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial 23b. DATE
1-30-86 23c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS
Sunset Mem. Park 23d. LOCATION
Cumberland Allegany Md.24. FUNERAL HOME
NAME
Jane E. Eichorn ADDRESS
Eichorn Funeral Home, Lonaconing, Md. 25a. DATE REC'D. BY REGISTRAR
JAN 31 1986 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Pondell

EDWARD E. BROWN, JR.
MAIN STREET
TOWNSEND, MA 01383

WIDBEE

98

Sept. 5, 1980

ATTICA COUNTY

DECEMBER 1980

RECORDED BY THE ATTICA COUNTY RECORDER

PAUL LIVGREN, M.D.

dated: 9-3-80

category: 9

041036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

B6 00084

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			CHARLES	RUSSELL	SNYDER	JANUARY 27, 1986				7:35A M	
3 SEX		4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian	MONTH DAY YEAR 09/16/1918			67		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) machine operator			12b. KIND OF BUSINESS OR INDUSTRY quarry			
CUMBERLAND		MEMORIAL HOSPITAL									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Cleveland St/ 15545 99999				
PA		Bedford	Hyndman								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE	LAST			
		Francis	Joseph	Snyder	Daisy			Beals			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) yes WWII 705-12-5538			17. INFORMANT		ADDRESS Virginia Snyder, Box 68, Hyndman, PA 15545				
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Carcinoma Left lung</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		DUE TO, OR AS A CONSEQUENCE OF (b)									
		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a		<i>Pneumonia, Silicosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on 1/27/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did not view the body after death.					22b. SIGNATURE <i>Shane Nathan</i>		22c. DATE SIGNED 1/27/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
DR. NATHAN							MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND, MARYLAND 21502				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. DATE			
Burial		01/30/86		Hyndman Cemetery		Hyndman, Bedford, PA		FEB 03 1986			
24. FUNERAL DIRECTOR <i>Shane Nathan</i>		ADDRESS Harvey (H. Zeigler, Hyndman, PA 15545			25a. DATE		25b. DATE				

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be attached.

B TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove from the State Dept. of Health and Mental Hygiene under "Burial, cremation or other arrangements".

IMPORTANT: If item 21 is marked or item 18 is checked, attach a separate sheet giving details of any injury, or other traumatic event, the medical cause of which resulted in death.

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WILLIAM J. WOOD

1. FOR
STATE
REGISTRAR
FUNERAL HOME
ROCKWOOD, PASTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

P 6 00085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be

submitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completed, it should be deposited for use in the burial permit. Then please remove carbon paper. Page 4 and 2 should be deposited with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked "Yes", item 18 shows injury, or other traumatic event, the

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR				2b HOUR	
Merle Ray Snyder							01	17	86	00:35a _m		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		6 6 16			69					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
PA.		USA					Allegany County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Cumberland		Sacred Heart Hospital					Carpenter			Building		
13a STATE		13b COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Pa		Somerset		Rockwood				RD 2 Rockwood Pa				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Arthur				Snyder	Sadie Enos Snyder			Enos		Pa.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes		World War II		206033977/1			Betty Snyder					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Oat all ca of the lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>with widespread metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>17-30</u> 19 <u>86</u> , to <u>1-17</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1-16</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>J. Mehanna</u>		22c. DEGREE <u>H-1</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <u>1-19-86</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ADDRESS 909-B Seton Drive, Cumberland, Md. 21502							
Dr. J. N. Mehanna												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/20/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Joof Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Rockwood Somerset Pa</u>		23e. COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <u>Francis Brody</u>		ADDRESS <u>933 Broadway Pa</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 03 1986</u>			25b. REGISTRAR'S SIGNATURE <u>Suzanne Davidson Rendell</u>					

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www.EasyEngineering.net

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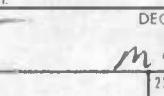
annex 3.5.3

023088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
				RUTH	S	SOLOMON	January 17, 1986				3:30 A.M.				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		Month Day Year June 15, 1915		70		YRS		MONTHS DAYS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.							
Maryland		U.S.A.				Allegany									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Cumberland		Memorial Hospital		Homemaker		Home									
13a STATE Maryland		13b COUNTY Allegany		13c CITY OR TOWN Cumberland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Cumb. Nurs. Home / 21502							
14 FATHER'S NAME FIRST Floyd		MIDDLE -		LAST Stickley		15. MOTHER'S MAIDEN NAME FIRST Minnie		MIDDLE -		LAST Ferguson					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
No		218-70-1297		Ethel Schramm - 25 E. Mary St., Cumberland, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES MELLITUS</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE 		22c. DEGREE M.D.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED 1/17/86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		Dr. Susan Schwartz		22f. ADDRESS Frostburg Plaza Frostburg, Md. 21532											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1-20-86		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION CITY OR TOWN Cumberland-Allegany Co.-Md.		23e. COUNTY STATE							
24. FUNERAL DIRECTOR NAME George-Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, Md. 21502				25a. DATE REC'D. BY REGISTRAR JAN 21 1986		25b. REGISTRAR'S SIGNATURE 									
DHMH - 16 60M 7/84 (VRA 15, 4)															

...and I SAW

022081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transt permit. Then please remove certificate from patient folder and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury or other trauma to the deceased, attach a separate sheet.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8600081			
1 - STATE REGISTRAR									REG. NO.						
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Layton		H		Stott					1		13	86		M	
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		MONTH 6 DAY 5 YEAR 21			64		MONTHS YRS.		DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.								
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY CITY STREET DEPT.								
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 183 Grant Street 21532							
14. FATHER'S NAME FIRST ALBERT		MIDDLE STOTT		15. MOTHER'S MAIDEN NAME NELLIE		16. LAST PORTER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 212 18 1174			17. INFORMANT MRS. LAYTON STOTT, 83 GRANT ST.,		FROSTBURG, MD 21532								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION															
{ DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		Aug 19 82 to Jan 13 1986, that (I) (we) lost above, (I) (we) did (did not) view the body after death.			22b. SIGNATURE Dr. S. Chang M.D.		22c. DEGREE								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. S. Chang		22e. ADDRESS					22f. DATE SIGNED 1/13/86								
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 1/15/86		23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM PK			23d. LOCATION CITY OR TOWN FROSTBURG		COUNTY ALLEGANY		STATE MD				
24. FUNERAL DIRECTOR Sowers Funeral Home		60 ADDRESS W. MAIN ST. FROSTBURG			25a. DATE REC'D. BY REGISTRAR JAN 17 1986		25b. REGISTRAR'S SIGNATURE Julie Gardner Purser								

160520



160520

031023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8500088

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
<i>George E. Thomas, Sr.</i>						1	21	86	935 AM			
3. SEX			RACE	S. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
male			white	09-28-1908				77	YRS	MONTHS	DAYS	IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
WV			USA					Allegany MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Frostburg			Frostburg Village Nursing Home				ret. brakeman			railroad		
13a STATE			13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE				
MD			Allegany	Cumberland				220 Somerville Avenue/21502				
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS					
Daniel Thomas					Delsie Moore							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			232-26-0328		Mrs. Juanita V. Thomas, Cumberland, MD - wife		20 days					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY			DUE TO, OR AS A CONSEQUENCE OF									
IMMEDIATE CAUSE (a)			<i>Cerebrovascular accident</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) <i>Atherosclerosis</i>									
{			DUE TO, OR AS A CONSEQUENCE OF									
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive lung disease, prior cerebrovascular accident, atherosclerotic coronary disease.</i>												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive above (we) did (did not) view the body after death		Aug 25, 1985		to Jan 21, 1986		that (I) (we) last						
above (we) did (did not) view the body after death		Jan 19, 1986										
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	22c DATE SIGNED			
<i>Thomas J. Deutle, MD</i>		MD.							1-21-86			
23a PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		23e COUNTY	STATE			
Thomas J. Deutle, MD		55 Jackson St., Coscarini, MD.		Levels Cemetery		Levels		Hampshire	WV			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 01-24-1986		23c DATE REC'D. BY REGISTRAR JAN 27 1986		23b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendell</i>						
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		ADDRESS										

036051

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
			PAULINE WYOMIA THOMPSON			Jan. 26, 1986			7:34 a M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White-Cau.			12 ^{MONTH} 5 ^{DAY} 18 ^{YEAR}			67 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
W.VA.			USA						Allegany MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Housewife			Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
			MD. Allegany						619 Baker Street 21502		
14. FATHER'S NAME			13b. COUNTY			13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME		
FIRST James			MIDDLE E.			LAST Moats			MIDDLE Chloe LAST Lease		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			213-80-6439			Gary E. Thompson LaVale, Md. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and in PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))						Cause of death					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			Due to, or as a consequence of Cause of death					
			(c)			Due to, or as a consequence of Cause of death					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-26-1986 to 1-26-1986, that (I) (we) last saw the deceased alive on 1-26-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Dr. William James									1/27/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			441 N. Centre St., Cumberland, Md. 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			1-29-86			Hillcrest Burial Park			Cumberland Allegany Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Silcox-Merritt 404 Decatur St., Cumb., Md.						JAN 30 1986			Gwen Jordan Parker		

be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remit payment of fees. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified since

B

referred by the hospital or attending physician.

legible

the best
and many others
are almost as good

042085

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Raymond Edward Thompson</i>						1	28	86	12 55 PM	M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		white		MONTH DAY YEAR		94		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MD		USA				Allegany					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Frostburg		Frostburg Village Nursing Home				retired		Plumbing			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MD		Allegany		Cumberland		405 Pulaski Street/21502					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
William E. Thompson			Elizabeth Liebrandt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no			217-10-6541			Mr. Vincent M. Thompson, Mt. Savage, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:			(a) <i>Carcinoma lung</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)			(b)			2 months					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(c)								
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE / <i>George Breza</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1-28-86					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			912 Seton Drive, Cumberland, MD 21502					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE			
Burial		01-31-1986		Hillcrest Burial Park		Cumberland		Allegany MD			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, MD 21502						FEB 03 1986		<i>James F. Scarpelli</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Reg. 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If item 18 shows any injury, or other transitory condition, mark it with an "X". Item 21 is marked with an "X" to indicate medical examiner may be consulted.

IMPORTANT If item 21 is marked with an "X" it will be forwarded to the medical examiner for examination.



031112

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 00091

1 - STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST JANET	MIDDLE MARIE	LAST THRASHER	2a DATE OF DEATH January 23, 1986	MONTH JAN	DAY 23	YEAR 1986	7b HOUR 9:27	PM	
3 SEX Female	4 RACE White	S. DATE OF BIRTH MONTH DAY YEAR August 31, 1935	6 AGE (IN YEARS LAST BIRTHDAY) 50	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	7c HOUR 9:27	PM					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Allegany MD.									
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b KIND OF BUSINESS OR INDUSTRY Own Home							
13a STATE Md.	13b COUNTY Allegany	13c CITY OR TOWN Cumberland	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 519 Caroline Street 21502								
14. FATHER'S NAME FIRST Nack	MIDDLE --	LAST Shoop	15. MOTHER'S MAIDEN NAME FIRST Evelyn	MIDDLE --	LAST Cheshire							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. 218 30 0154	17 INFORMANT Mr. Gordon Thrasher Jr. 519 Caroline Street	ADDRESS Cumberland, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Heart Massive Myocardial Infarct APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
(b) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Disease												
(c) DUE TO, OR AS A CONSEQUENCE OF Tobacco Abuse.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE 												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ranjithan			DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22e DATE SIGNED 1/24/86		22e ADDRESS 500 Memorial Ave. Memorial Med. Bldg. Cumberland, MD 21502			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/26/86	23c NAME OF CEMETERY OR CREMATORIAL Queens Point Cem.	23d. LOCATION CITY OR TOWN Keyser	23e COUNTY Mineral	23f STATE W. Va.							
24 FUNERAL DIRECTOR Harold S. McKenzie	ADDRESS ARKWOOD McKENZIE Funeral Home, Keyser, W. Va.	25a DATE REC'D. BY REGISTRAR JAN 20 1986	25b REGISTRAR'S SIGNATURE									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3
relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove the original copy of this certificate and mail it with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other injury, or other significant condition contributing to death, medical examination must be submitted at time of death.

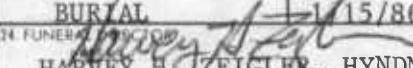
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

022125

86 00092

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			JOHN	DAVID	TIMBROOK	JANUARY 12, 1986				10:30A		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER : YEAR		
MALE		CAUCASIAN	MONTH DAY YEAR			78				IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MONTHS DAYS HOURS MIN		
W. VA.		USA	05/07/07			ALLEGANY				MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL			LABORER				RETAIL			
13a. STATE PA		13b. COUNTY SOMERSET	13c. CITY OR TOWN HYNDMAN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE RD 1, BOX 374/15545 99999		
14. FATHER'S NAME FIRST PHILLIP		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME MINNIE			16. ADDRESS LOY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. WWII			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES		232-26-0382			DOROTHY BRYANT, BOX 374, RD, HYNDMAN, PA 15545							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic myeloid Leukemia</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE 		22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/12/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Memorial Hospital Medical Building Cumberland, Maryland 21502										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1/15/86		23c. NAME OF CEMETERY OR CREMATORIAL COMPS CEMETERY			23d. LOCATION RD HYNDMAN, SOMERSET, PA					
24. FUNERAL DIRECTOR 		ADDRESS HARVEY H. ZEIGLER, HYNDMAN, PA 15545			25a. DATE REC'D. BY REGISTRAR JAN 16 1986				25b. REGISTRAR'S SIGNATURE 			
DHMH - 16 60M 7/84 (VRA 15-4)												

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B6 00093

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			MILDRED	A.	TROUTMAN	January 17, 1986				7:05 A.M.	
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR	
Female			Caucasian	MONTH 07/14/20 YEAR		65				MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				10. KIND OF BUSINESS OR INDUSTRY	
MD			USA			Allegany MD				Homemaker	
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Cumberland			Memorial Hospital						12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
PA			Somerset	Hyndman			R D 1/15545 Southampton Twp 99999				
FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS				
Jacob			Bridges		Frances		Richard Troutman, R D 1, Hyndman, PA 15545				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			184-42-6094								
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cardio-Respiratory Arrest								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF Brain Stem Hemorrhage								
{			{						{		
DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) did not view the body after death.											
22b. SIGNATURE 		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 1/18/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Medical Building Memorial Hospital		23a. NAME OF CEMETERY OR CREMATORIAL Comps Cemetery		23d. LOCATION RD, Hyndman, Somerset, PA		23b. COUNTY			STATE
Dr. Zaman											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1/20/86		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION RD, Hyndman, Somerset, PA		23b. REGISTRAR'S SIGNATURE			
Burial											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harvey H. Zeigler, Hyndman, PA		15545									

be enclosed within 24 hours after death. Page 4 may be attached.

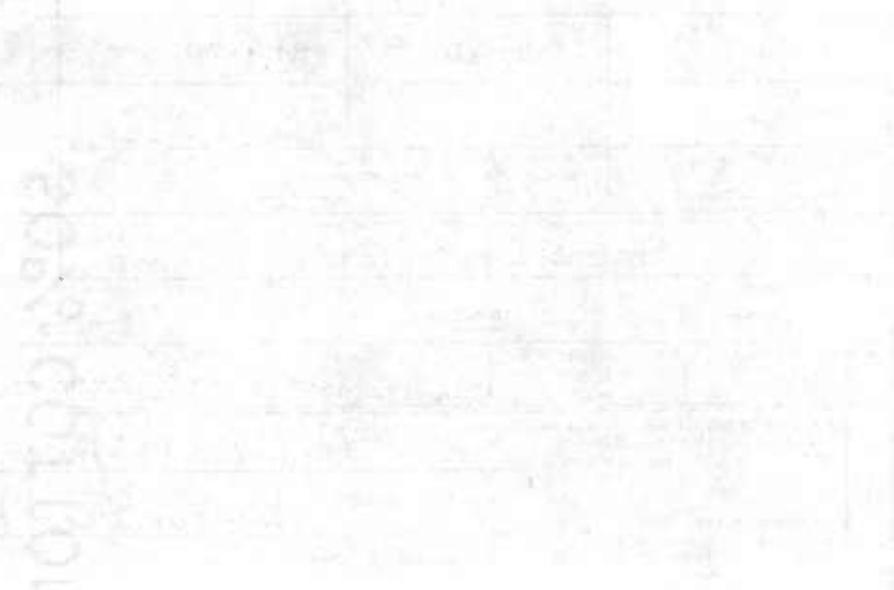
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician it should be detached for use as the burial permit. Then please remit this to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, file a report with the State Dept. of Health and Mental Hygiene.

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retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-trust permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the deceased. If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										R 6	00094					
										REG. NO.						
1. FOR STATE REGISTRAR		FIRST Lula			MIDDLE B		LAST Truly			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)										1/7/86				11:36a m		
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		MONTH 5/30/04 DAY			YEAR			81	YRS		MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE STATE OR FOREIGN (TRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Alleg.						
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frostburg Community Hospital		12a. USUAL OCCUPATION Homemaker			12b. KIND OF BUSINESS OR INDUSTRY OF BUSINESS Own Home									
13a. STATE Maryland		13b. COUNTY Alleg		13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Back ST, Midland, MD 21542						
14. FATHER'S NAME George		MIDDLE Miller		15. MOTHER'S MAIDEN NAME Victoria			16. ADDRESS Md. Edward Truly Rt 1, Box 524 Frostburg,			MIDDLE Van Buskirk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Edward Truly						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH: Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY HEART DISEASE																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a DIABETES MELLITUS																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE Dr. H. Sidhu M.D.										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. H. Sidhu										22e. DATE SIGNED 1-7-86						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. DATE 1-9-86		23b. NAME OF CEMETERY OR CREMATORIUM Sunset Mem. Park			23c. LOCATION Cumberland Allegany Md									
24. FUNERAL DIRECTOR NAME John Eichhorn		ADDRESS Eichhorn Funeral Home		25a. DATE REC'D. BY REGISTRAR JAN 9 1986			25b. REGISTRAR'S SIGNATURE John Dawson-Pandell									

013066

DIVISION OF VITAL RECORDS, 201 W. PELTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT MARM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PELTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

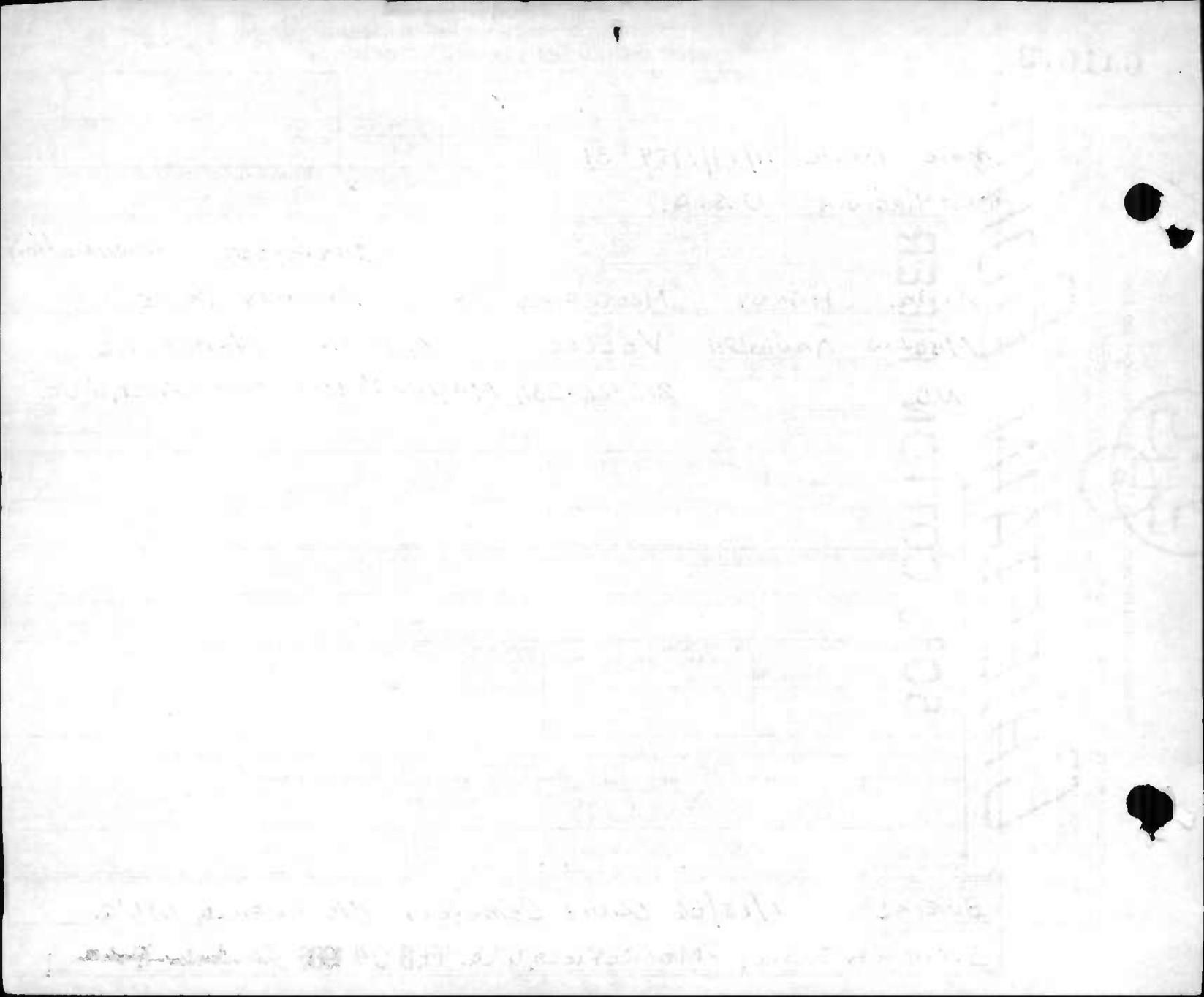
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG NO. 00095		
1- STATE REGISTRAR														
1a. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR	
John R. Uhl Jr.								<input checked="" type="checkbox"/>		1	6	1986	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR
Male	Cau	May 24 1904		81 yrs						1		6 1986		0910
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA								Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY
Cumberland		108 Wilmont Ave.						Int. Rev. Service Gov.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		ADDRESS				
Maryland		Allegany		Cumberland				108 Wilmont		21502				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
John		Robert		UHL Sr.		Mary				Carder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-05-5778						17. INFORMANT		ADDRESS				
								Rose Uhl		Cumberland, Md. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		sudden												
(b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF		years												
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Dpty		MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Memorial Hospt. Cumberland Md 21502												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 1-8-86		23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul		23d. LOCATION CITY OR TOWN Cumberland Allegany Md.		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME		ADDRESS Leasure-Stein Inc. 230 Baltimore Ave.		25a. DATE REC'D. BY REGISTRAR JAN 9 1986		25b. REGISTRAR'S SIGNATURE								

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PLENTY IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. ST., BALTIMORE, MD. 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00096	
1. FOR STATE REGISTRAR			2. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-12-86 19 M										
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES			MIDDLE W.			LAST VETTER			3. HOUR		
3. SEX Male		4 RACE white		5. DATE OF BIRTH MONTH 11 DAY 14 YEAR 1954		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. HOURS		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 1-12-86 19		2d. HOUR 12:15A					
9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County		MD											
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		
13a. STATE W.Va.		13b. COUNTY HARDY		13c. CITY OR TOWN MOOREFIELD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS TANNERY ROUTE 99999		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
14. FATHER'S NAME FIRST MELTON MIDDLE RANDOLPH LAST VETTER		15. MOTHER'S MAIDEN NAME FIRST MARTHA MIDDLE HEAVENER LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-66-2311		17. INFORMANT ADDRESS MARTHA VETTER - MOOREFIELD, W.Va									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 1 HOUR A.M. MONTH 1-1986 YEAR P.M. 19			21c. HOW INJURY OCCURRED driver of auto/fixed object collision (ENTER NATURE OF INJURY IN ITEM 19a)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown			21f. LOCATION STREET CITY OF ALLEGANY COUNTY, STATE Allegany Co., Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) Assistant MEDICAL EXAMINER	
ACTUAL SIGNATURE Margarita A. Korell, M.D.												DATE 1-12-86 SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		111 Penn Street ADDRESS											
23a. BURIAL, CREMATION, REMOVAL RECEIPT Burial		23b. DATE 1/15/86		23c. NAME OF CEMETERY OR CREMATORIAL Olivet Cemetery			23d. LOCATION CITY OR TOWN MOOREFIELD, W.Va		COUNTY STATE				
24. FUNERAL DIRECTOR NAME J.T. Thomas Frealey - MOOREFIELD, W.Va.		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 04 1986		25b. REGISTRAR'S SIGNATURE M. A. Korell							



031030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201. If Item 21 is marked "Yes," attach a copy of the medical certificate to this page.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 86 00091				
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
			Stanley			W			Warne			1/ 19/ 86				7:12p
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS			
male		white		MONTH 9/ DAY 11/ YEAR 98			87			MONTHS			HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA					Allegany Co									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Frostburg, Md		Frostburg Community Hospital		Mechanic			Auto Co.									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Frostburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 164 W. Main St., 21532						
14. FATHER'S NAME FIRST Daniel		MIDDLE W.		LAST Warne			15. MOTHER'S MAIDEN NAME FIRST Margaret			MIDDLE			LAST Humbertson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		16c. INFORMANT			16d. ADDRESS									
		216 01 8814		Mrs. Helen Chaney, La Vale, Maryland 21502												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) COPD & pulmonary hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart failure Renal failure															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Renal failure																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) this hospital attended the deceased from now the deceased alive on Jan 17, 1986, to Jan 18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE Helen Chaney		22c. DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 1/21/86												
22e. PHYSICIAN'S NAME, TITLE OR POSITION Dr. C. Oh		22f. ADDRESS 48 Tarn Terrace, Frostburg, Md 21532														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 22, 1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Anns Cemetery			23d. LOCATION CITY OR TOWN Avilton, Garrett, Md.			COUNTY			STATE			
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 27 1986			25b. SIGNATURE John Durst									

060160

1000m. elevation

SEEDS estimated at 1000 m. elevation
and rainfall 1000 mm.

Rooted seedlings categorized
as follows: 1) Lined

2) Unrooted seedlings 10 mm. tall

All other categories were omitted.
Total 1000

031076

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please return both papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21a is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

FOR SHAFFERS FUNERAL HOME 1 - STATE 230 E. MAIN ST. ROMNEY WV REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE			8 6 0 0 0 9 8									
						CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2d DATE OF DEATH		MONTH		DAY		YEAR		2d HOUR			
CHARLES	WESLEY		WARNER SR.	JANUARY 18, 1986								7:45AM			
3. SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 15 1917	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.								
7a BIRTHPLACE COUNTRY West Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD.												
10 CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL	12a USUAL OCCUPATION Supervisor, Maint.		12b KIND OF BUSINESS OR INDUSTRY School Dist.											
13a STATE WV	13b COUNTY Hampshire	13c CITY OR TOWN Levels	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE General Delivery 25431										
ATHER'S NAME FIRST Noah	MIDDLE Warner	15 MOTHER'S MAIDEN NAME FIRST Cordelia	MIDDLE		LAST Pickett										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236073297A	17. INFORMANT Colleene M. Warner		ADDRESS Levels, WV 25431											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Metastatic ca of St. Ova APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	DUE TO, OR AS A CONSEQUENCE OF (b) Stroke - brain -														
DUE TO, OR AS A CONSEQUENCE OF (c) COPD with Failure.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from 1-16 1986 to 1-18- 1986 that (I) (we) last saw the deceased alive on 1-17 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE <i>John Mehanna</i>		22c DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED 1-20-86								
22e PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.															
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/86		23c NAME OF CEMETERY OR CREMATORIAL Levels Cemetery		23d. LOCATION CITY OR TOWN Levels		COUNTY Hampshire		STATE WV					
24. FUNERAL DIRECTOR NAME Shaffer Funeral Home, Romney, WV 26757		25. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE <i>John S. Shaffer</i>											

SHINING BREEZE HOME
100 E. MAIN ST. ROME NY

870160

3827, 37 YANMAI.

RENTAL

YARD

CHARGE

YTHUO YADELLA

GARRISON TRACT CEROSA

AC02370072

ROBERT M. WILKINS JR. 100 E. MAIN ST. ROME NY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and delivered to you, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please file this certificate within 72 hours after death. Page 4 may be used for any funeral director's notes.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR ROALS FUNERAL HOME STATE REGISTRAR 11½ CHURCH ST. WESTERNPORT			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				00099				
CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			REG. NO.					
MARTHA LOUIS WASHINGTON											
2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR					
JANUARY 4, 1986			9:30 P.M.								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		6 11 DAY 1904		81		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY		MD.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH ACTIVITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY House			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10 G Jane Frazier Village 21502			
14. FATHER'S NAME Wm.		MIDDLE L Washington LAST		15. MOTHER'S MAIDEN NAME Sarah							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. no 235-74-1775		17. INFORMANT Mr. Lorraine Kithcart Piedmont, W.Va.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF 1b) CARCINOMA OF LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF 1c)		6 months.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/28/1985 to 1/4/1986, that (I) (we) last saw the deceased alive on 1/4/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Arvind Pathak</i>		22c. DEGREE <i>M.D.</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARVIND PATHAK, M.D.		22e. ADDRESS 913 SETON DRIVE CUMBERLAND, MD. 21502		22f. DATE SIGNED 1/15/86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/86		23c. NAME OF CEMETERY OR CREMATORIAL Potomac Memorial Gardens		23d. LOCATION CITY OR TOWN Keyser Mineral W. Va.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Wayne Borth		ADDRESS Boral Funeral Service Westernport, Md. 21562		25a. DATE REC'D. BY REGISTRAR JAN 13 1986		25b. REGISTRAR'S SIGNATURE <i>Jane Frazier Borth</i>					
BP											
DHMH - 16 60M 7/B4 (VRA 15, 4)											

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ROTRUCK FUNERAL HOME
85 S. MAIN STREET
KEYSER, WV 26726STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
00100

1- FOR STATE REGISTRAR			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR		
JAMES HERMAN WEBB			JANUARY 24, 1986		
3. SEX Male			2b. HOUR 4:00P M		
4. RACE Cau					
5. DATE OF BIRTH MONTH DAY YEAR Oct 12 1938			6. AGE (IN YEARS LAST BIRTHDAY) 47 IF UNDER 1 YEAR MONTHS DAYS YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE WV			13b. CITY OR TOWN COUNTY Mineral Keyser		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 155 Baker Street 26726		
14. FATHER'S NAME FIRST Herman MIDDLE L. LAST Webb			15. MOTHER'S MAIDEN NAME FIRST Vivian MIDDLE T. LAST Wood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -- 232-62-7121		
17. INFORMANT Louise Webb 155 Baker St Keyser, WV 26726			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17 myeloma - advanced cirrhosis DUE TO, OR AS A CONSEQUENCE OF (b) liver & brain DUE TO, OR AS A CONSEQUENCE OF (c) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-17-86 to 1-24-86, that (I) (we) last saw the deceased alive on 1-24-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JOHN MEHANNA, MD		DEGREE MD.		22c. DATE SIGNED 1-26-86	
22d. ATTENDING PHYSICIAN MD.		22e. ADDRESS 909-B SETON DR., CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/86		23c. NAME OF CEMETERY OR CREMATORIAL Queens Point Cemetery	
23d. LOCATION CITY OR TOWN Keyser		23e. COUNTY Mineral		23f. STATE WV	
24. FUNERAL DIRECTOR NAME A. Craig Rotruck 85 S Main St Keyser, WV 26726		25a. DATE REC'D. BY REGISTRAR JAN 31 1986		25b. REGISTRAR'S SIGNATURE John C. Rotruck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this certificate.

999999
BP

MONDAY MORNING 10:00 AM
FEBRUARY 19, 1968
82782 MI 93273

3001 3001 AC VENTILATION

8001 JAMESON 2345

YUAN YUAN LIA

CONTRACTOR'S NAME

JETTECH TRASH SERVICES

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00101

014098

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

Mary Irene Weisenmiller

2a DATE KNOWN
OF
ESTI-
DEATH MATED

MONTH DAY YEAR

2b HOUR

1 6 1986 M

3 SEX

Female

4 RACE

Cau

5. DATE OF BIRTH

MONTH DAY YEAR

09 18 1901

6 AGE (IN YEARS)
LAST BIRTHDAY

84 YRS.

IF UNDER 1 YR.

MONTHS

DAYS

HOURS

MIN.

2c DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

2d HOUR

1 6 1986 M

7a BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Maryland

10 CITY OR TOWN OF DEATH

Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

735 Fayette St

1 BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Housewife

12b KIND OF BUSINESS
OR INDUSTRY

Own Home

13a STATE

Maryland

13b COUNTY

Allegany

13c CITY OR TOWN

Cumberland

13d. INSIDE CITY LIMITS?

YES NO

13e STREET ADDRESS

735 Fayette / 21502

14. FATHER'S NAME

FIRST

Patrick

MIDDLE

LAST

Porter

15. MOTHER'S MAIDEN NAME

Margaret

ADDRESS

Kreitzburg
Route 2, Box 28
John Weslow - Frostburg, MD 21532

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

sudden

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

16b SOCIAL SECURITY NO.

219-54-1986

17. INFORMANT

years

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

Pulmonary arrest

IMMEDIATE CAUSE (a)

9293

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

Chronic obstructive pulmonary disease

DUE TO, OR AS A CONSEQUENCE OF

(b)

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

Previously resected kidney for hemorrhage 1984 ; old hip fracture

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES NO

21a EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK AT WORK

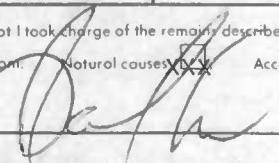
21e PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE 

TITLE (SPECIFY)

Dpty

M.D.

MEDICAL EXAMINER

DATE SIGNED 1/6/86

EXAMINER'S NAME
(TYPE OR PRINT)

ADDRESS Memorial Hosp. Cumberland Md 21502

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Jan 9, 1986

23c. NAME OF CEMETERY OR CREMATORI

Hillcrest Burial

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Cumberland, Alleg., MD

24. FUNERAL DIRECTOR

NAME

John J. Hafer, Jr.

ADDRESS LaVale, MD 21502

25a. DATE REC'D. BY REGISTRAR

JAN 16 1986

25b. REGISTRAR'S SIGNATURE

100000

49 boat is to

analyse

smaller or larger

SORT

medium

medium

large

large

2000 - 2500 - 3000 - 3500 - 4000 - 4500 - 5000 - 5500 - 6000 - 6500 - 7000 - 7500 - 8000 - 8500 - 9000 - 9500 - 10000 - 10500 - 11000 - 11500 - 12000 - 12500 - 13000 - 13500 - 14000 - 14500 - 15000 - 15500 - 16000 - 16500 - 17000 - 17500 - 18000 - 18500 - 19000 - 19500 - 20000 - 20500 - 21000 - 21500 - 22000 - 22500 - 23000 - 23500 - 24000 - 24500 - 25000 - 25500 - 26000 - 26500 - 27000 - 27500 - 28000 - 28500 - 29000 - 29500 - 30000 - 30500 - 31000 - 31500 - 32000 - 32500 - 33000 - 33500 - 34000 - 34500 - 35000 - 35500 - 36000 - 36500 - 37000 - 37500 - 38000 - 38500 - 39000 - 39500 - 40000 - 40500 - 41000 - 41500 - 42000 - 42500 - 43000 - 43500 - 44000 - 44500 - 45000 - 45500 - 46000 - 46500 - 47000 - 47500 - 48000 - 48500 - 49000 - 49500 - 50000

to



031026

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death within the State Dept. of Health and Mental Hygiene either in Bureau, cremation, or other traumatic event, incineration, or removal.

IMPORTANT: If item 21 is marked on Item 18 above, any injury or other traumatic event, incineration, or removal.

999999 BP

THOMAS FUNERAL HOME
101 GRANT STREET
SALISBURY, PA 15558

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00102

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

2a. DATE OF DEATH MONTH DAY YEAR

2b. HOUR

CATHERINE E WELLINGTON

01 21 86 02:14 AM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
May 22 1926

6. AGE (IN YEARS LAST BIRTHDAY)

59
YRS

IF UNDER 1 YEAR

UNDER 24 HRS.
MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE STATE OR FOREIGN COUNTRY

Brownsville, Pa

7b. CITIZEN OF WHAT COUNTRY?

USA

8.

MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

ALLEGANY COUNTY

MD.

10. CITY OR TOWN OF DEATH

Lumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

SACRED HEART HOSPITAL

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Pa

13c. COUNTY

Somerset

13d. CITY OR TOWN

Boynton

13e. INSIDE CITY LIMITS?
YES NO

13f. STREET ADDRESS / ZIP CODE

Boynton, Pa

15832 99999

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Sheridan

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Priscilla

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

199206130

17. INFORMANT

ADDRESS
Thomas F Wellington Boynton, Pa 15532APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(b) arteriosclerotic coronary artery disease years

DUE TO, OR AS A CONSEQUENCE OF

(c) void

void

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

none

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES NO YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

[IF EITHER, NOTIFY MEDICAL EXAMINER]

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

[ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]

21d. INJURY OCCURRED

21e. PLACE OF INJURY

21f. LOCATION

CITY OR TOWN COUNTY STATE

WHILE AT WORK NOT WHILE AT WORK AT WORK 22a. I certify that (I) (the hospital) attended the deceased from 1-19-1979 to 1-21-1986, that (II) (we) lost
saw the deceased alive on 6-27-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN

22c. DATE SIGNED

1-22-86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Grant Atwell, M.D.

22e. ADDRESS

Salisbury, Pa. 15558

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

1-24-86

23c. NAME OF CEMETERY OR CREMATORIUM

SALISBURY CEMETERY

23d. LOCATION

CITY OR TOWN COUNTY STATE
SALISBURY - SOMERSET Pa.

24. FUNERAL DIRECTOR

NAME

Garfield F Thomas

ADDRESS

101 GRANT ST
SALISBURY, PA 15558

25a. DATE REC'D. BY REG. OFFICER

JAN 27 1986

25b. REG. OFFICER

John D. [unclear]

11120 28 19 10

METTLETON

CALIFORNIA

101 CROWN STREET
BOSTON, MASS. 02114
TELEGRAMS 12221

100100

11120 28 19 10

LAWRENCE CALIFORNIA

100100

B

041053

STATE OF MARYLAND B 6 00103
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRARROTTRUCK F.H.
85 S. MAIN STREET
KEYSER, WV 26726

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
WALTER			EDWIN WESTROM			01	26	86		20:10 M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Cau	MONTH	DAY	YEAR	75	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Minister		
13a. STATE WV		13b. COUNTY Mineral	13c. CITY OR TOWN Burlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Rt 1 Box 32 99999			
14. FATHER'S NAME FIRST Victor		MIDDLE Edward	LAST Westrom	15. MOTHER'S MAIDEN NAME FIRST Lula		MIDDLE		LAST Woolhiser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. --		17. INFORMANT		ADDRESS		Burlington, W.Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) _____								
		DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-9 1986, to 1-26 1986, that (I) (we) last saw the deceased alive on 1-26 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>John Mehanna</i>		DEGREE R.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-27-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEHANNA, M.D.		22e. ADDRESS 909-B SETON DRIVE, CUMBERLAND, MD 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/29/86		23c. NAME OF CEMETERY OR CREMATORIAL Lahmansville Cemetery		23d. LOCATION CITY OR TOWN Lahmansville		STATE WV		
24. FUNERAL DIRECTOR NAME A. Craig Rottruck 85 S Main St Keyser, WV 26726		25a. DATE REC'D. BY REGISTRAR FEB 03 1986 25b. REGISTRAR'S SIGNATURE <i>Jeanne Wilson-Roth</i>								

ROGATION DAY

RECEIVED 2011-02-28

2012 MAR 14 2011

00100

36 39 40

ELVANIA WESLEY

WATSON

WILCOX MCGEE

SACRED HEART HOSPITAL

00100 36 box 1 of 25

MINISTER

RECEIVED 2011-02-28

2012 MAR 14 2011

600-0 SECTION 6000, UNIVERSITY OF TEXAS

JOHN HENRY WILSON

031114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of body.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other significant event, the medical certifying physician should be consulted.

FOR STATE REGISTRAR			GEORGE UPCHURCH F.H. 202 GREENE STREET CUMBERLAND, MD 21502		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		6 0 0 1 0 4			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST				REG. NO.			
Carl Bell Whetzel										
2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		
January		26,		1986				04:35am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		White		MONTH DAY YEAR		64		# MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
West Virginia		U.S.A.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Sacred Heart Hospital		Potomac Edison Company						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN						12623-A McMullen Hwy. / 21502		
Maryland	Allegany	Cumberland								
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Lorenzo G. Whetzel		Gladys - Dean								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO W.W.II 232267360/1		17. INFORMANT		ADDRESS				
				Mary Whetzel-Address same as #13 above.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) BRAIN STEM INFARCTION								30 MINUTES		
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC C.V. DISEASE								6 Weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12/25/1986 to 12/13/1985, to 12/26/1986, that (I) (we) lost sow the deceased alive on above, (I) (we) did not see the body after death.										
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				12/26/86				
Arvind Pathak M.D.		913 Seton Drive, Cumberland, Md. 21502								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY STATE		
Burial		1-29-86		Sunset Memorial Park		Cumberland-Allegany-Maryland				
24. FUNERAL DIRECTOR NAME		George-Upchurch Funeral Home, P.A.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
202 Greene Street-Cumberland, Md. 21502				JAN 29 1986		John Upchurch				

George H. Morris
800 George Street
Cambridge, MA 02139

1961 Oct 28

Dear George,

Enclosed

CARDIO RESEARCH LAB 36 Wm St

Cardiovascular Institute

36 Wm St. U.S.A.

28 1961 28 1961 28 1961

28/10/61

4th floor

28/10/61

4th floor

TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND 8 6
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00105

031103

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Mary	MIDDLE A.	LAST Whitefield	2a. DATE OF DEATH MONTH 01	MONTH DAY 24	YEAR 86	2b. HOUR 4:50 M		
3. SEX <input checked="" type="checkbox"/> Female	4. RACE <input checked="" type="checkbox"/> White	5. DATE OF BIRTH MONTH 4		DAY 2	YEAR 1905	6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? usa	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany				MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lions Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. General Motore Car				12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Seton Drive 21502					
14. FATHER'S NAME George	FIRST Simon	MIDDLE Clark	LAST	15. MOTHER'S MAIDEN NAME Mary		FIRST E.	MIDDLE Ross	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 384-18-9290	17. INFORMANT Mrs. Norman Rankin		ADDRESS Westernport, Md. 21562						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last					DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerotic peripheral vascular disease</u>					
					DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Multi infarction dementia</u> .										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-6</u> , 19 <u>84</u> , to <u>1-24</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>1-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>V. A. Ranjithan</u>	DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>1-24-86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. A. Ranjithan, M. D.				22e. ADDRESS LMNH, Seton Drive, Cumberland, MD 21502						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/28/86	23c. NAME OF CEMETERY OR CREMATORIAL Roseland Park			23d. LOCATION CITY OR TOWN Berkley		COUNTY Oakland	STATE Michigan		
24. FUNERAL DIRECTOR NAME Boals Funeral Service	ADDRESS Westernport, Md. 21562				25a. DATE REC'D. BY REGISTRAR JAN 29 1986		25b. REGISTRAR'S SIGNATURE			

501770

04 2012 2 4

x

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2012 04 04 000000 000000 000000 000000

2012 04 04 000000 000000 000000 000000

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036142

MARKWOOD MCKENZIE FUNERAL HOME STATE OF MARYLAND
KEYSER, WVA 26726 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00106

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME <i>ARTHUR LEE WILMOTH</i>			2a DATE OF DEATH JANUARY 28, 1986	MONTH YEAR	2b HOUR 6:37 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY MD		
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur Railroad	
12b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. Va.	13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 98 James Street 26726	12b. KIND OF BUSINESS OR INDUSTRY Railroad
14. FATHER'S NAME FIRST Orland	MIDDLE --	LAST Wilmoth	15. MOTHER'S MAIDEN NAME FIRST Carrie	MIDDLE --	LAST Gainer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 705 10 7692	17. INFORMANT Mrs. Arthur L. Wilmoth, 98 James St.	ADDRESS Keyser, W. Va.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 P Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cardiovascular arrest</i> 26 D (c) <i>Atherosclerosis</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Maywood Jr.</i>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Maywood Jr.</i>		22e. ADDRESS BMG 912 SETON DRIVE, CUMBERLAND, MD 21502			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/86	23c. NAME OF CEMETERY OR CREMATORIAL Potomac Memorial Gardens, Keyser, Mineral, W. Va.	23d. LOCATION CITY OR TOWN Mineral, W. Va.	COUNTY STATE
24. FUNERAL DIRECTOR <i>J. - McKenzie</i>		ADDRESS Markwood-McKenzie Funeral Home, Keyser, W. Va.	25a. DATE REC'D. BY REGISTRAR FFB 03 1986	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered to the funeral director. Then place among funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, report to medical examiner.

RECEIVED - MAIL ROOM
JULY 10, 1968

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FRENCH COUNTY

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SUGAR HILL HOSPITAL



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00107

REG. NO.

1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR														
1. DECEASED NAME FIRST MIDDLE LAST			2b. HOUR														
Roselima Conner Wilson			4:30 P.M.														
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7b. IF UNDER 1 YEAR			8b. IF UNDER 24 HRS		
Female			White			March 18, 1914			71 YRS								
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Allegany County MD.								
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1034 Frederick Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper			12b. KIND OF BUSINESS OR INDUSTRY Retail								
13a. STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Cumberland			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1034 Frederick St. 21502					
14. FATHER'S NAME FIRST Harvey MIDDLE LAST Conner			15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Eva LAST Pressman														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-05-5596			17. INFORMANT Luther C. Wilson			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHF</i>			19. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) _____			DUE TO, OR AS A CONSEQUENCE OF			(c) _____			<i>one year</i>					
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>10</i> of (I) (we) lost <i>11/13</i> saw the deceased alive on <i>19</i> , <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (and not) view the body after death.																	
22b. SIGNATURE <i>W. Guy Fiscus</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS Cumberland, Maryland 21502			22e. DATE SIGNED <i>14/8</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1/14/86			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Crematory			23d. LOCATION CITY OR TOWN Frederick			COUNTY Fred. Maryland STATE					
24. FUNERAL DIRECTOR NAME Leasure-Stein Funeral Home			25a. DATE REC'D. BY REGISTRAR JAN 16 1986			25b. REGISTRAR'S SIGNATURE <i>Leasure-Stein</i>											
230 Baltimore Ave. Cumberland, MD 21502																	

30030

020233

BOALS FUNERAL HOME
111 CHURCH STREETSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00108

REG. NO.

FOR
STATE
REGISTRAR

WESTERNPORT, MD 21562

1. DECEASED NAME
(TYPE OR PRINT)

FIRST LAST

LAST

2a DATE OF DEATH MONTH DAY YEAR

2b HOUR

01/09/86

10:28A

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
3 19 1910

6. AGE (IN YEARS LAST BIRTHDAY)

75

YRS.

IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8

MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

ALLEGANY COUNTY

MD

10. CITY OR TOWN OF DEATH

Cumberland

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SACRED HEART HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Mechanic

12b. KIND OF BUSINESS OR INDUSTRY

Paper

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE
Maryland13c. COUNTY
Garrett13d. CITY OR TOWN
Swanton13e. STREET ADDRESS / ZIP CODE
Rt2 Box 237 21561

14. FATHER'S NAME

Theopholis

MIDDLE
GeorgeLAST
Wilt

15. MOTHER'S MAIDEN NAME

FIRST
Martha

MIDDLE

LAST
Wilt

16a. WAS DECEASSED EVER IN U.S. ARMED FORCES?

(YES OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
217-03-6069

17. INFORMANT

Mrs. Emma Wilt

ADDRESS

Swanton, Md. 21561

18. CAUSE OF DEATH (Enter only one cause per line for 18, (b), and
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a))

Shock Profound Cardiogenic → Coma.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lastDOUE TO, OR AS A CONSEQUENCE OF
(b) Possible Myocardial Infarction & Cardiac ShockDOUE TO, OR AS A CONSEQUENCE OF
(c) Severe CAD & CHT

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (b)

Fracture of the Insula.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)

20a. AUTOPSY?

YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES NO Paralyzed brain
not ready21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 21, PART I OR PART II)

21d. INJURY OCCURRED

WHITE NOT WHITE AT WORK 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

above, (I) (we) (did) (did not) view the body after death.

12/20/85 1985 to 1/5/86

1986, that (I) (we) lost

soe the deceased alive on 12/20/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN MEDICAL
DIRECTOR STAFF
PHYSICIAN 22c. DATE SIGNED
1/10/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

V. RUAL FELIPA, MD

22e. ADDRESS

925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

1/11/86

23c. NAME OF CEMETERY OR CREMATORI

Philos Cemetery

23d. LOCATION
CITY OR TOWN

Westernport Allegany Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Boals Funeral Service

ADDRESS

Westernport, Md. 21562

25a. DATE REC'D. BY REGISTRAR

JAN 16 1986

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return it to the attending physician as soon as possible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or embalming.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and completely filled in by the funeral director, page 3) should be detached for use on the burial form given. Then please remove carbon copies, pages 1 and 2 and keep them with the death certificate until it is filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

028002

NEWMAN FUNERAL HOME
FOR STATE P.O. BOX 267
REGISTRAR GRANTSVILLE, MD 21536

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

00109

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
HARRY RUBEN WILT						JANUARY 15, 1986			4:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		6/6/1908		77 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Cumberland		SACRED HEART HOSPITAL		Laborer		Construction					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Garrett		Grantsville				RRoute 2, Box 158		21536	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS			
Jesse				Wilt		Rachael		Route 2, Box 158		21536	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS		APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH	
No		213-12-9705		Mrs. Sarah A. Wilt		Pneumonia		Route 2, Box 158		7 days	
19. MEDICAL CERTIFICATION		20. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED <small>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AS WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12, 1985, to 1/15, 1985, that (I) (we) last saw the deceased alive on 1/15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		BMG, 912 SETON DR. CUMBERLAND, MD 21502							
Wayne C. Spiggle, Jr. M.D.											
23a. BURIAL, CREMATION, REMOVAL <small>UNCH</small> Burial		23b. DATE 1/18/86		23c. NAME OF CEMETERY OR CREMATORIUM Grantsville Cemetery		23d. LOCATION CITY OR TOWN Grantsville, Garrett, MD		COUNTY		STATE	
24. FUNERAL DIRECTOR <i>D. Lynn Newman</i>		ADDRESS Giantsville, MD		25a. DATE REC'D. BY REGISTRAR JAN 24 1986		25b. REGISTRAR'S SIGNATURE <i>J. Newman</i>					

MEMPHIS AIRPORT POLICE

100 BOX 515

GRADUATE RD 7724

002030

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3321 35 YAMA

HARD RUMINANT

ATTICA COUNTY

2000-1907-012

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
			WILLIAM	LEVI	WINNER	January 20, 1986				7:55 A.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 18, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS YRS. DAYS		# UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE COUNTRY Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Allegany		MD		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction				
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN LaVale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Cash Valley Road/21502		
14. FATHER'S NAME FIRST Peter		MIDDLE Clarence		LAST Winner		15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE Katherine		LAST Price
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? UNKNOWN Yes		16b. SOCIAL SECURITY NO. GIVEN IN WAR ORDATES WW 1L		16c. INFORMANT Wm. C. Winner		17. INFORMANT Wm. C. Winner		44438		
								591 Brookfield Ave. Masury, Ohio		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATIC and RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATO-RENAL SYNDROME</u> } DUE TO, OR AS A CONSEQUENCE OF (c) <u>LAENNOC'S CIRRHOSIS</u>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>GASTROINTESTINAL BLEEDING due to ESOPHAGEAL VARICES</u>										
19a. DATE OF OPERATION 1-16-86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE JAUNDICE due to COMMON DUCT STONES		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHITE WORKER <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (We) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.										
22b. SIGNATURE <u>Ado Torres</u>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/20/86				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Amado Torres		22g. ADDRESS Memorial Hospital Medical Bldg. Cumberland, MD 21502								
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/24/86		23c. NAME OF CEMETERY OR CREMATORY Brookfield Twsp.		23d. LOCATION CITY OR TOWN Brookfield Trumbull Oh.				
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr.		ADDRESS LaVale, Md. 21502		25a. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign in the attending physician and complete section 18. Fill in the funeral director's name and address in section 24.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the medical examiner, it should be detached for use as the burial permit. Then please remove carbon papers. Please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained until payment of the gratuity and removal expenses have been made to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign below.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be



ROTRUCK FUNERAL HOME 85 S. MAIN ST. KEYSER, WV 26726

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

022107

00

FOR
STATE
REGISTRAR
KEYSER, WV 26726

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
LEWIS RAYMOND WOLFORD						JANUARY 9, 1986				6:50 PM	
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH Dec DAY 24 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ALLEGANY COUNTY					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Govt		12b. KIND OF BUSINESS OR INDUSTRY Postal Service					
13a. STATE WV		13b. COUNTY Mineral	13c. CITY OR TOWN Keyser	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 117 E. Piedmont Street 26726					
FATHER'S NAME FIRST Henry		MIDDLE McGoy	LAST Wolford	15. MOTHER'S MAIDEN NAME FIRST Rhoda		LAST Albright					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 722-18-5873		17. INFORMANT Pauline L. Wolford		ADDRESS 117 E. Piedmont St Keyser, WV 26726					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute myocardial Infarction è cardiogenic shock</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i>									
		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Respiratory failure</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the _____ date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Baljeet Mahal</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALJEET MAHAL		22e. ADDRESS 909-B SETON DR. CUMBERLAND, MD 21502									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/12/86		23c. NAME OF CEMETERY OR CREMATORIAL Philos Cemetery		23d. LOCATION CITY OR TOWN Westernport		COUNTY Allegany		STATE MD	
24. FUNERAL DIRECTOR NAME A. Craig Rotruck		ADDRESS 85 S Main St Keyser, WV 26726		25a. DATE REC'D. BY REGISTRAR JAN 16 1986		25b. REGISTRAR'S SIGNATURE <i>Julie Swanson</i>					
DHMH - 16 60M 7/84 (VRA 15, 4)											

SEARCHED INDEXED
SERIALIZED FILED
FEB 2 1968
FBI - NEW YORK

RECEIVED FEBRUARY 12 1968

ALLEGIAN COUNTY

SEARCHED INDEXED SERIALIZED FILED

FEB 18 1968

SEARCHED INDEXED SERIALIZED FILED
FEB 18 1968

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 0 1 2

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1A AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1-
FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

Mary

FIRST

MIDDLE

LAST

2a DATE KNOWN
OF DEATH
ESTIMATED

X

MONTH

DAY

YEAR

2b HOUR

1

5

86

19

M

3 SEX
Female4 RACE
Cau5 DATE OF BIRTH
MONTH DAY YEAR
OCT. 2, 19006 AGE (IN YEARS
LAST BIRTHDAY)
85 YRS.7 IF UNDER 1 YR.
MONTHS DAYS HOURS MIN2c DATE
PRONOUNCED
DEAD

X

MONTH

DAY

YEAR

2d HOUR

1

5

86

M

7b BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Maryland

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED NEVER MARRIED
WIDOWED DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

Allegany

MD.

10 CITY OR TOWN OF DEATH

Cumberland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1105 Frederick Street

12a USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Practical Nurse

12b KIND OF BUSINESS
OR INDUSTRY

Medicine

13a STATE

Maryland

13b COUNTY

Allegany

13c CITY OR TOWN

Cumberland

13d INSIDE CITY LIMITS?

YES NO

14 STREET ADDRESS -

1105 Frederick Street / 21502

14. FATHER'S NAME

John

FIRST

MIDDLE

LAST

Vincent Yarnall

15. MOTHER'S MAIDEN NAME

Elizabeth

FIRST

MIDDLE

LAST

T. Hart

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

No

16b SOCIAL SECURITY NO.

183-12-5820

17. INFORMANT

Mary Y. Brake - Chevy Chase, Maryland

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which

gave rise to immediate

cause (a) stating the under-

lying cause last.

Acute congestive heart failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Acute congestive heart failure

minutes

DUE TO, OR AS A CONSEQUENCE OF

(c) Cardio-vascular heart disease

years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES NO

P.M.

UNDERLYING ORCONTRIBUTING CAUSE OF DEATH

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

P.M.

19

21d INJURY OCCURRED

21e PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

WHILE NOT WHILE AT WORK AT WORK

22a I certify that I took charge of the remains described above, held an

Autopsy Inspection Inquiry

and in my opinion

death resulted from

Natural causes Accident Suicide Homicide Undetermined manner 23a ACTUAL
SIGNATURE

TITLE (SPECIFY)

Dpty

M.D.

MEDICAL EXAMINER

DATE
SIGNED

1/5/86

EXAMINER'S NAME
(TYPE OR PRINT)

Paul Snow, M.D.

ADDRESS Memorial Hosp. Cumberland Md 21502

23b BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b DATE

Burial

1-8-86

23c NAME OF CEMETERY OR CREMATORI

St. Mary's Cemetery

23d LOCATION
CITY OR TOWN

Cumberland-Allegany Co.-MD.

COUNTY STATE

24 FUNERAL DIRECTOR
NAME

George-Upchurch Funeral Home, P.A.

25b REGISTRAR'S SIGNATURE

ADDRESS

202 Greene Street-Cumberland, Md. 21502

25b DATE REC'D. BY REGISTRAR

JAN 8 1986

PC 0016

1938 IN LETTERS

